



## QUALITY AND PATIENT SAFETY COMMITTEE AGENDA

Date Issued: July 14, 2015

The Quality and Patient Safety Committee of the Board of Directors of the Cook County Health and Hospitals System will meet on **Tuesday, July 21, 2015** at the hour of **10:30 A.M.** at 1900 W. Polk Street, in the Second Floor Conference Room, Chicago, Illinois, to consider the following:

	<u>Time/Presenter</u> (times are approximate)
<b>I. Attendance/Call to Order</b>	<b>10:30</b> /Chairman Gugenheim
<b>II. Public Speakers</b>	<b>10:30-10:40</b>
<b>III. Report from Chief Quality Officer</b>	<b>10:40-10:50</b> /Dr. K. Das
A. Regulatory and Accreditation Updates	
B. Metrics	
C. Report – CORE Center / HIV Care	<b>10:50-11:15</b> /Dr. D. Barker
D. Report - Illinois Surgical Quality Improvement Collaborative (ISQIC)	<b>11:15-11:30</b> /Dr. M. Wille
<b>IV. Action Items</b>	
A. Executive Medical Staff (EMS) Committees of Provident Hospital of Cook County and John H. Stroger, Jr. Hospital of Cook County	<b>11:30-11:40</b> /Dr. A. Hussain and Dr. O. Ukoha
i. Receive reports from EMS Presidents	
ii. **Approve Medical Staff Appointments/Re-appointments/Changes	
B. Minutes of the Quality and Patient Safety Committee Meeting, June 16, 2015	<b>11:40-11:45</b> /Chairman Gugenheim
C. Any items listed under Sections IV and V	
<b>V. Closed Meeting Items</b>	<b>11:45-11:55</b>
A. Medical Staff Appointments/Re-appointments/Changes	
B. Litigation Matter(s)	

### Closed Meeting

Motion to recess the open meeting and convene into a closed meeting, pursuant to the following exceptions to the Open Meetings Act:

**5 ILCS 120/2(c)(1)**, regarding “the appointment, employment, compensation, discipline, performance, or dismissal of specific employees of the public body or legal counsel for the public body, including hearing testimony on a complaint lodged against an employee of the public body or against legal counsel for the public body to determine its validity,”

\*\* Also included as a potential Closed Meeting Item/Discussion under Section V.

**V. Closed Meeting Items (continued)**

**5 ILCS 120/2(c)(11)**, regarding “litigation, when an action against, affecting or on behalf of the particular body has been filed and is pending before a court or administrative tribunal, or when the public body finds that an action is probable or imminent, in which case the basis for the finding shall be recorded and entered into the minutes of the closed meeting,” and

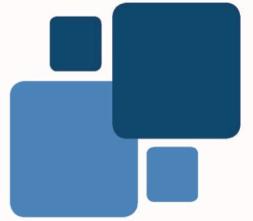
**5 ILCS 120/2(c)(17)**, regarding “the recruitment, credentialing, discipline or formal peer review of physicians or other health care professionals for a hospital, or other institution providing medical care, that is operated by the public body.”

**VI. Adjourn**

**Committee Members:**

Chairman: Gugenheim

Members: Board Chairman Hammock (Ex-Officio) and Directors Lerner and Marsh  
Patrick T. Driscoll, Jr. and Patricia Merryweather (Non-Director Members)



# COOK COUNTY HEALTH & HOSPITALS SYSTEM

CCHHS Board of Directors  
Quality and Patient Safety Committee  
Dashboard Overview

21 July 2015

Krishna Das, MD, Chief Quality Officer



COOK COUNTY HEALTH  
& HOSPITALS SYSTEM  
**CCHHS**

# Dashboard Overview

- Quality measures – process, outcome and efficiency
- Safety measures
- Patient satisfaction
- Hospitals and ambulatory are included



# Quality – Stroger

CCHHS QPS Committee Dashboard																		
Data as of 07/13/2015		CY 2014							CY 2015						TARGET	VARIANCE *		
PERFORMANCE MEASURES		Q2 2014		Q3 2014			Q4 2014		Q1 2015			Q2 2015						
		May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May				
<b>Core Measures</b>																		
Venous Thromboembolism (VTE) Prevention (%)	85	81	92	84	88	87	83	84	79	92	79	86	91	99	-8%			
Care for Stroke Patients (%)	94	95	95	97	96	97	93	91	96	93	92	87	91	100	-9%			
Influenza and Pneumococcal Vaccination (%)	59	45	47	53	62	74	68	68	66	67	64	36	48	90	-42%			
<b>Efficiency - Operating Room</b>																		
Surgery Begins at Scheduled Time (%)	38	48	38	41	32	35	45	35	30	47	62	56	52	80	-28%			
OR Room Turn Around Time (minutes)	52	49	51	48	54	57	54	50	51	45	45	43	45	35	-10%			



# Quality – Provident

CCHHS QPS Committee Dashboard																
Data as of 07/13/2015		CY 2014								CY 2015						
PERFORMANCE MEASURES		Q2 2014		Q3 2014			Q4 2014			Q1 2015			Q2 2015		TARGET	VARIANCE *
		May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May		
<b>Core Measures</b>																
Venous Thromboembolism (VTE) Prevention (%)	96	91	85	95	95	86	100	82	94	100	100	95	91	99	-8%	
Influenza and Pneumococcal Vaccinations (%)	80	82	64	77	62	78	71	89	93	79	95	93	90	90	3%	
<b>Efficiency - Operating Room</b>																
Surgery Begins at Scheduled Time (%)		5	25	14	10	13	28	15	19	12	17	45	70	80	-10%	
OR Room Turn Around Time (minutes)														35	na	



# Safety – Stroger

CCHHS QPS Committee Dashboard																
Data as of 07/13/2015		CY 2014								CY 2015					TARGET	VARIANCE *
PERFORMANCE MEASURES		Q2 2014		Q3 2014			Q4 2014			Q1 2015		Q2 2015				
		May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May		
<b>Safety</b>																
HAC: Pressure Ulcer Stages III & IV <sup>1</sup>		4	2	0	0	2	2	4	4	2	5	2	2	6		
HAC: Falls with Injury <sup>2</sup>		0	1	1	1	0	0	0	0	1	0	0	3	3		
HAI: CLABSI <sup>3</sup>		1	1	0	0	0	0	0	0	2	3	0	1	3		
HAI: CAUTI <sup>4</sup>		1	1	1	1	1	1	0	0	0	0	0	0	0		

LEGEND
CLABSI: Central line-associated blood stream infections
CAUTI: Catheter-associated urinary tract infections
*Variance is target to recent full quarter



# Patient Experience – Stroger

CCHHS QPS Committee Dashboard																		
Data as of 07/13/2015		CY 2014							CY 2015						TARGET	VARIANCE *		
PERFORMANCE MEASURES		Q2 2014		Q3 2014			Q4 2014			Q1 2015			Q2 2015					
		May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May				
<b>Patient Experience</b>																		
Willing to Recommend Hosp (% top box)	60	61	70	69	66	65	71	71	73	66	60	71	71	85	-14%			
Communication with Doctors (% top box)	77	78	84	84	83	78	86	84	87	82	78	85	85	88	-3%			
Communication with Nurses (% top box)	60	70	68	70	70	65	74	75	74	67	68	75	73	86	-13%			
Cleanliness (% top box)	44	51	57	52	49	52	43	50	57	49	42	57	48	77	-29%			



# Patient Experience – Provident

CCHHS QPS Committee Dashboard																		
Data as of 07/13/2015		CY 2014								CY 2015					TARGET	VARIANCE *		
PERFORMANCE MEASURES		Q2 2014		Q3 2014			Q4 2014			Q1 2015		Q2 2015						
		May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May				
<b>Patient Experience</b>																		
Willing to Recommend Hosp (% top box)	48	56	54	59	84	69	50	70	73	67	70	69	75	85	-10%			
Communication with Doctors (% top box)	97	85	85	85	72	95	74	81	82	92	93	82	75	88	-13%			
Communication with Nurses (% top box)	84	70	81	85	75	88	67	84	77	92	87	92	75	86	-11%			
Cleanliness (% top box)	62	75	69	52	53	64	69	65	87	62	50	42	75	77	-2%			



# ACHN

CCHHS QPS Committee Dashboard															
Data as of 07/13/2015		CY 2014						CY 2015						TARGET	VARIANCE *
PERFORMANCE MEASURES		Q2 2014		Q3 2014		Q4 2014		Q1 2015		Q2 2015					
		May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	
<b>ACHN</b>															
Diabetes Control % with Hgb A1C < 9%		73		77			78		74	73	73	73	74	78	-4%
Immunizations: Up to date in children at 24 months (%)		87		57			68		60	49	58	81	66	86	-20%
Patient Experience: Moving Through Visit		68		68			67		65	68	67	68	59	75	-16%
Patient Experience: Telephone Access		60		63			62		70	53	64	64	57	75	-18%

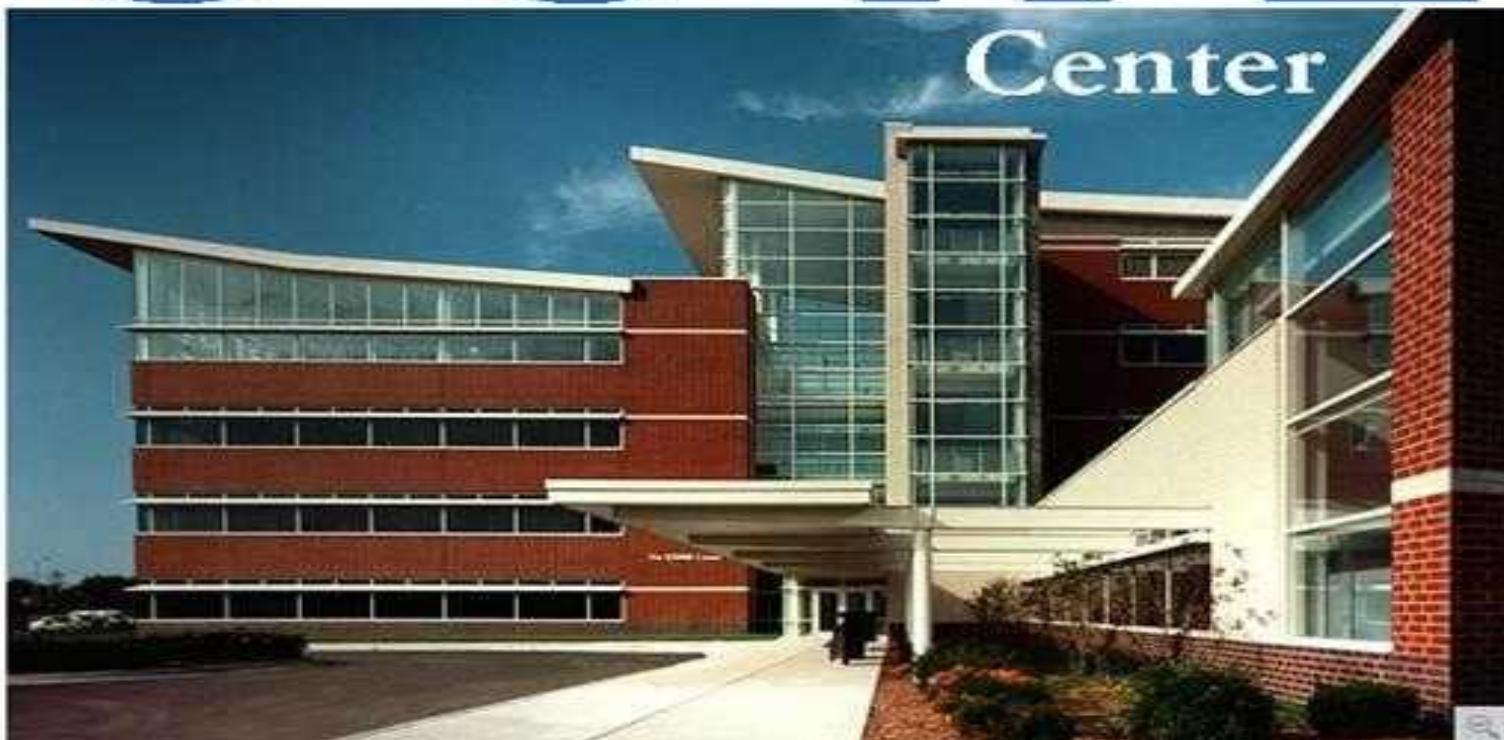


# Board Quality Dashboard

CCHHS QPS Committee Dashboard		CCHHS Board Metrics - Quality											
Data as of 07/13/2015		CY 2014				CY 2015				TARGET	VARIANCE*		
PERFORMANCE MEASURES		2Q14	3Q14	4Q14	1Q15	Apr	May						
<b>Stronger</b>													
<b>Core Measures</b>		<b>Monthly Composite</b>											
Venous Thromboembolism (VTE) Prevention (%)		80	88	85	83	84	91	99%	-8%				
<b>Efficiency - Operating Room</b>		<b>Monthly %</b>											
Surgery Begins at the Scheduled Time (%)		44	37	38	46	56	52	80%	-28%				
<b>Safety</b>		<b>Total # of Events</b>											
Events: Ulcers, Falls, CLABSI and CAUTI		29	26	13	22	6	12						
<b>Patient Experience</b>													
Willing to Recommend Hosp (% top box)		62	68	69	66	71	71	85%	-14%				
<b>Provident</b>													
<b>Core Measures</b>													
Venous Thromboembolism (VTE) Prevention (%)		90	92	89	98	95	91	99%	-8%				
<b>Efficiency - Operating Room</b>		<b>Monthly %</b>											
Surgery Begins at the Scheduled Time (%)		44.3	37	38	16	45	70	80%	-10%				
<b>Patient Experience</b>													
Willing to Recommend Hosp (% top box)		56	66	63	70	69	75	85%	-10%				
<b>ACHN</b>													
Diabetes Control % with Hgb A1C < 9%		73	77	78	73	73	74	78%	-4%				
Patient Experience: Moving Through Visit		68	68	67	67	68	59	75%	-16%				
Patient Experience: Telephone Access		60	63	62	62	64	57	75%	-18%				
<b>LEGEND</b>													
CLABSI: Central line-associated blood stream infections													
CAUTI: Catheter-associated urinary tract infections													
*Variance is target to recent full quarter													



# Ruth M. Rothstein CORE



## July 2015 Quality and Patient Safety Committee Report

Dave Barker, MD, MPH – CORE Chief Medical Officer

Jennifer Catrambone – CORE Director of QI and Evaluation

Stephon Effinger - CORE Patient Information Coordinator

Ron Lubelchek MD – CORE Associate Medical Director

# CORE Quality Plan

- Understand how our patients feel about how we serve them, – CORE Patient Satisfaction Survey
- Evolve toward the metrics of the National HIV/AIDS Strategy
  - Treatment cascade as promoted by the CDC / IOM / CMS / NHAS
  - Large scale – public health approach to HIV Care
  - Emphasis on HIV testing within CCHHS
- Ensure timely access to the services we provide
- Measure Outcomes and Processes that matter
  - HRSA / HAB / HIVQual measures
  - Primary Care Measures
- Pre-Exposure HIV Prophylaxis

# eDocuments as appendices

- CORE QA Plan
- 2015 CORE Patient Satisfaction Survey (PSS)
- How CORE PSS differs from Press-Gainey
- CORE Patient Satisfaction Survey 2014
  - including departmental modules
- Results of CORE Return to Care Survey 2014

## Ruth M Rothstein CORE Center - Patient Satisfaction Survey - 2015

Please think about your visits to CORE over the last 12 months when you answer these questions. Your responses will be kept private, so please be honest!

- Use a No. 2 pencil or a blue or black ink pen only.
- Do not use pens with ink that soaks through the paper.
- Make solid marks that fill the response completely.
- Make no stray marks on this form.

CORRECT: ●

INCORRECT: ○⊗◐○

1. I have received medical care here for...

- (1) less than 1 year      (2) 1-2 years      (3) 3 to 5 years      (4) more than 5 years

2. I would rate my health today as...      (5) excellent      (4) very good      (3) good      (2) fair      (1) poor

3. My last visit here was...      (1) less than 1 month ago      (2) 1-2 months ago      (3) 3-6 months ago      (4) more than 6 mos. ago

### Access to HIV Care (in the last 12 months...)

4. Did you ever call CORE to make an appointment or talk to someone about your care? (1) yes (2) no

5. If yes, what was it like when you called the clinic? (please select all that apply)

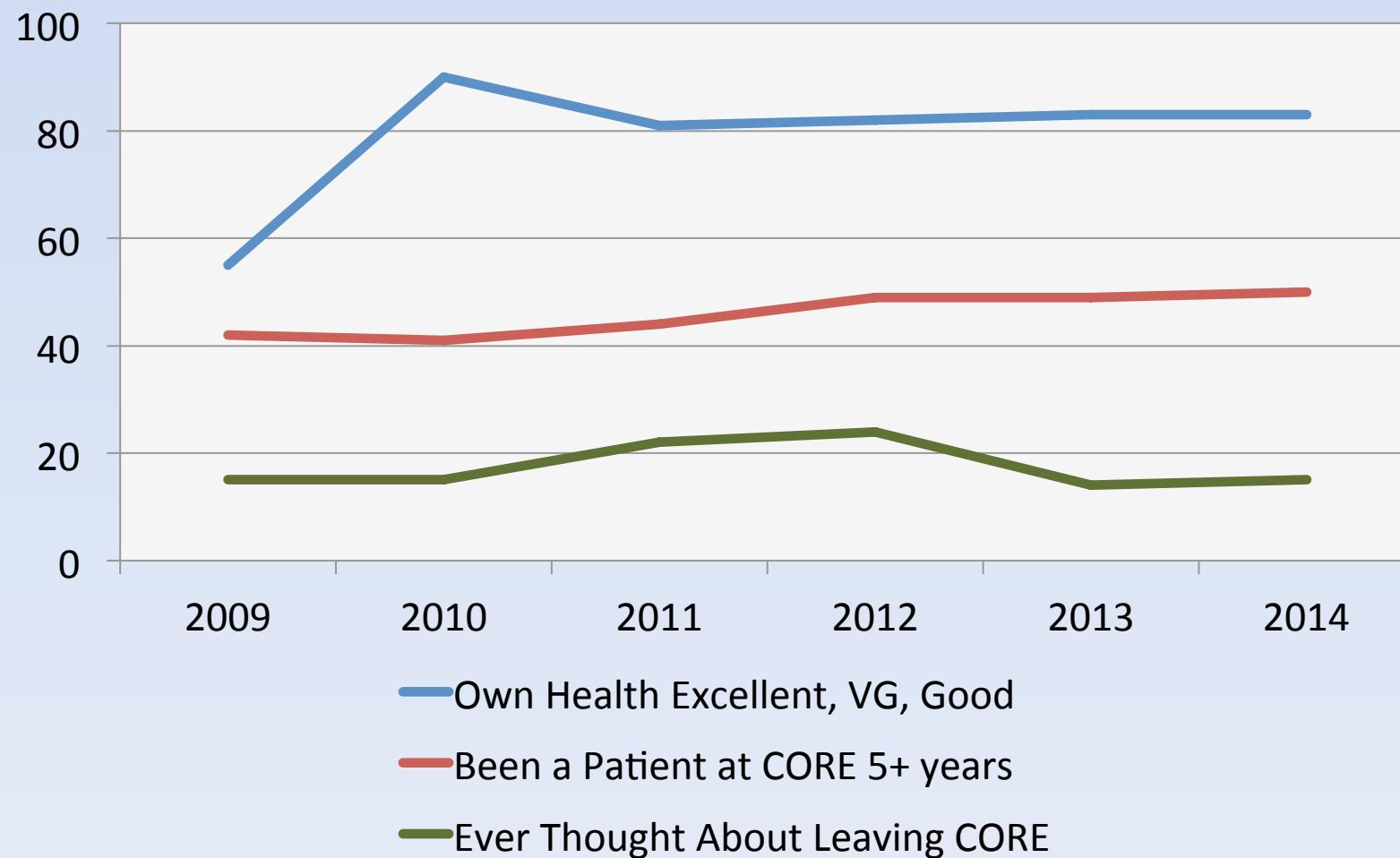
- (1) I got the help I needed  
(2) I got a busy signal or was disconnected  
(3) I was put on hold too long  
(4) I left a message and no one called me back  
(5) The phone rang many times before it was answered  
(6) The person who answered the phone was unfriendly  
(7) I talked to several different people before talking to the right person

6. When I needed an appointment, I could schedule one soon enough for my needs.

all the time	most times	un-decided	rarely	never	NA
(5)	(4)	(3)	(2)	(1)	NA

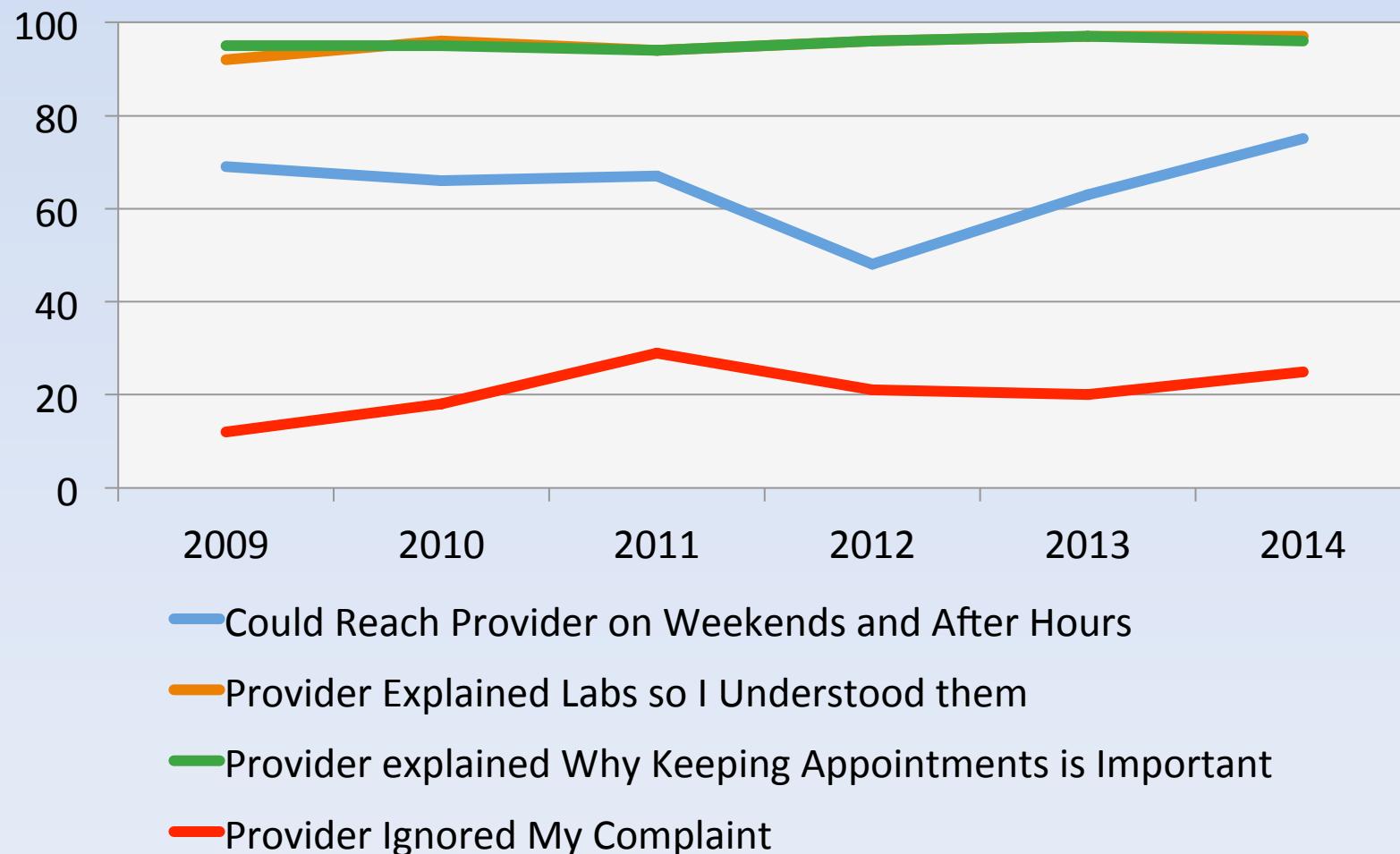
## CORE Patient Satisfaction Survey – 2009 - 2014

Overall n=380 for 2014



## CORE Patient Satisfaction Survey – 2009 - 2014Q1

### Providers

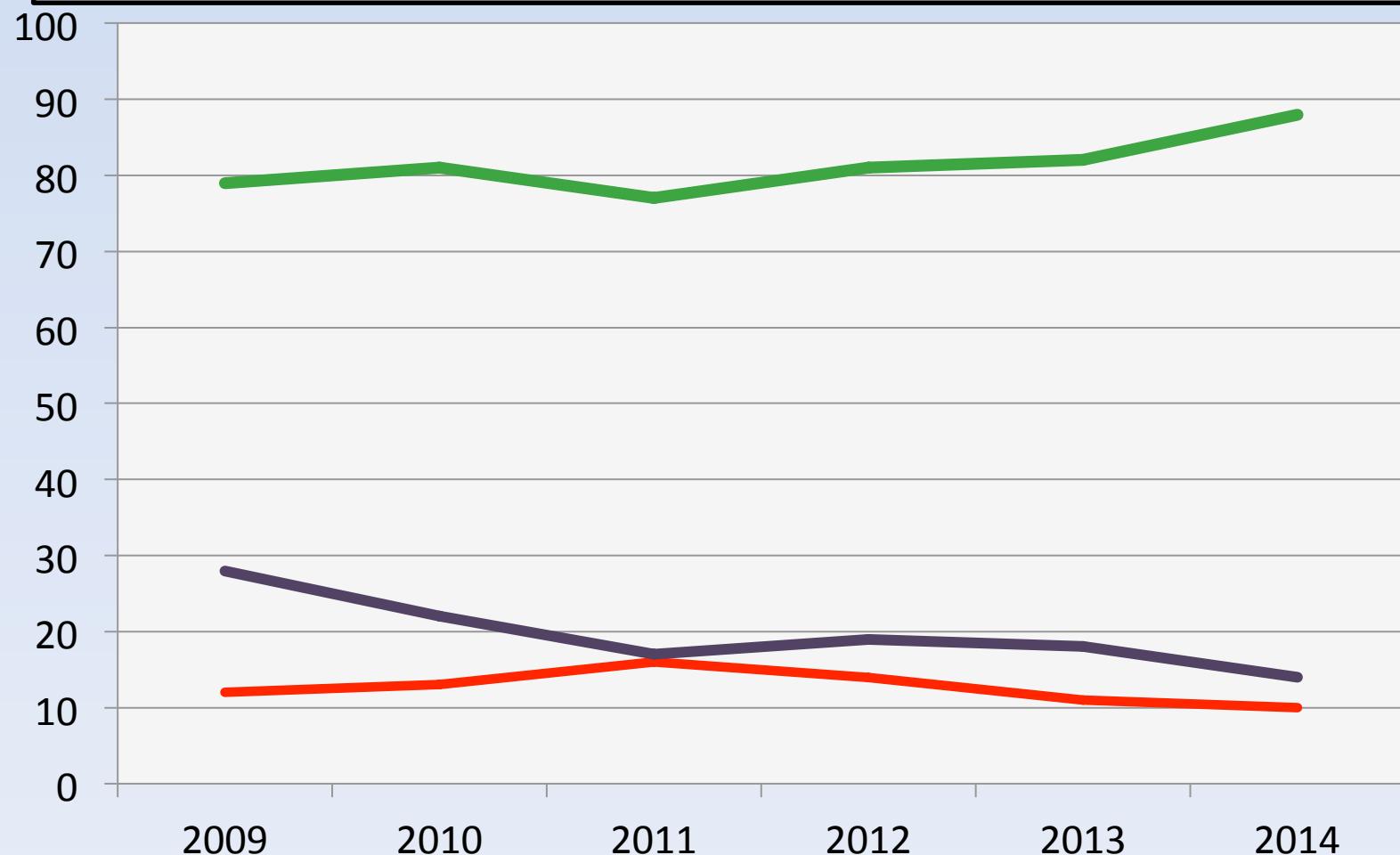


## CORE Patient Satisfaction Survey – 2009-2014

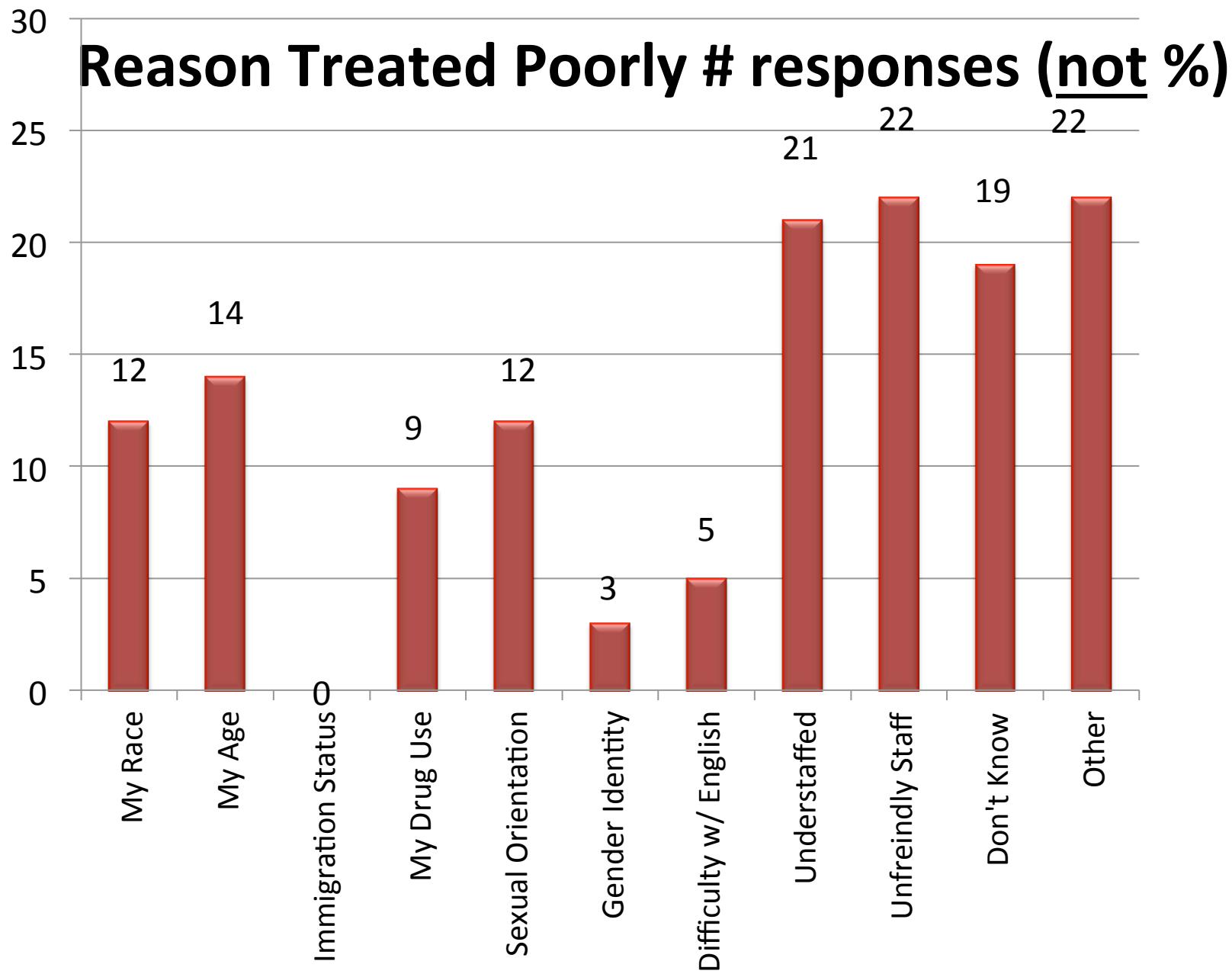
Ever Treated Poorly by Anyone at CORE in past year — —

Staff Unfriendly — —

Definitely Yes : Rec this clinic to friends/family with HIV —

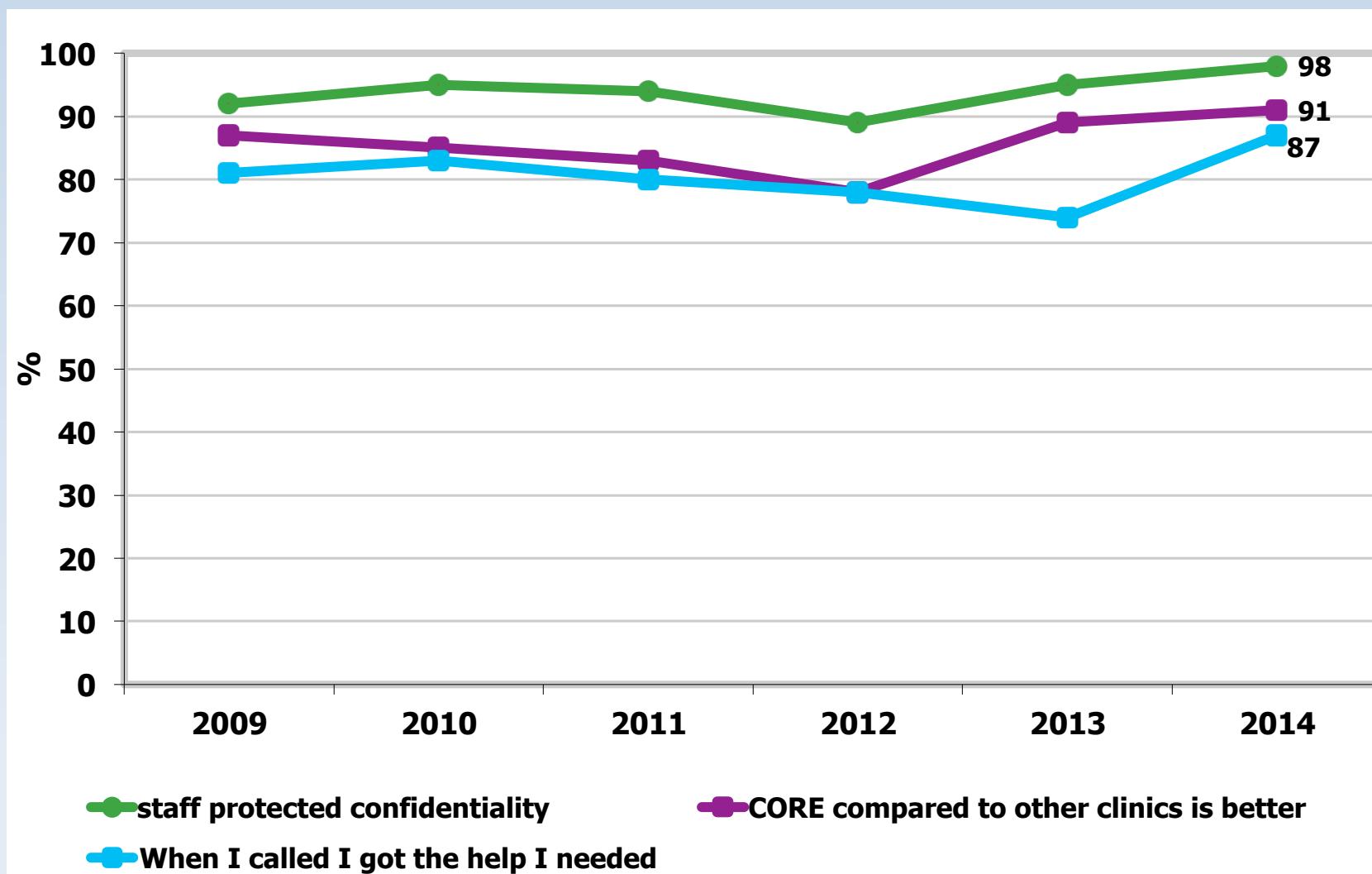


## **Ever Treated Poorly by Anyone at CORE in past year**



## CORE Patient Satisfaction Survey – 2009 - 2014

Overall

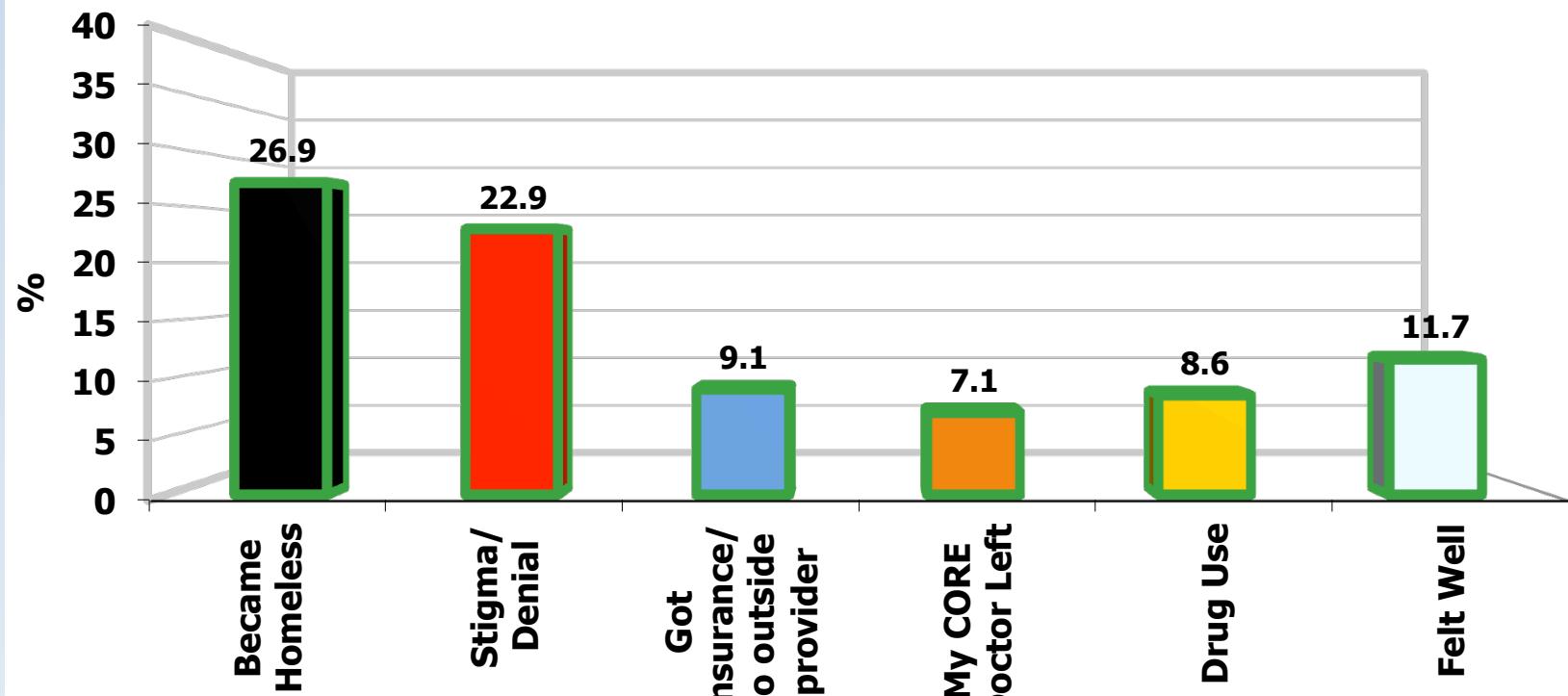


## **Over 90% of our patients report...**

- Being able to get appointments soon enough for their needs
- Feeling involved in their health care decisions
- Being able to get their referrals
- Feeling their confidentiality is protected

## 2014 CORE Return to Care Survey top 3 reasons for leaving (patient gone >1 yr)

N=221

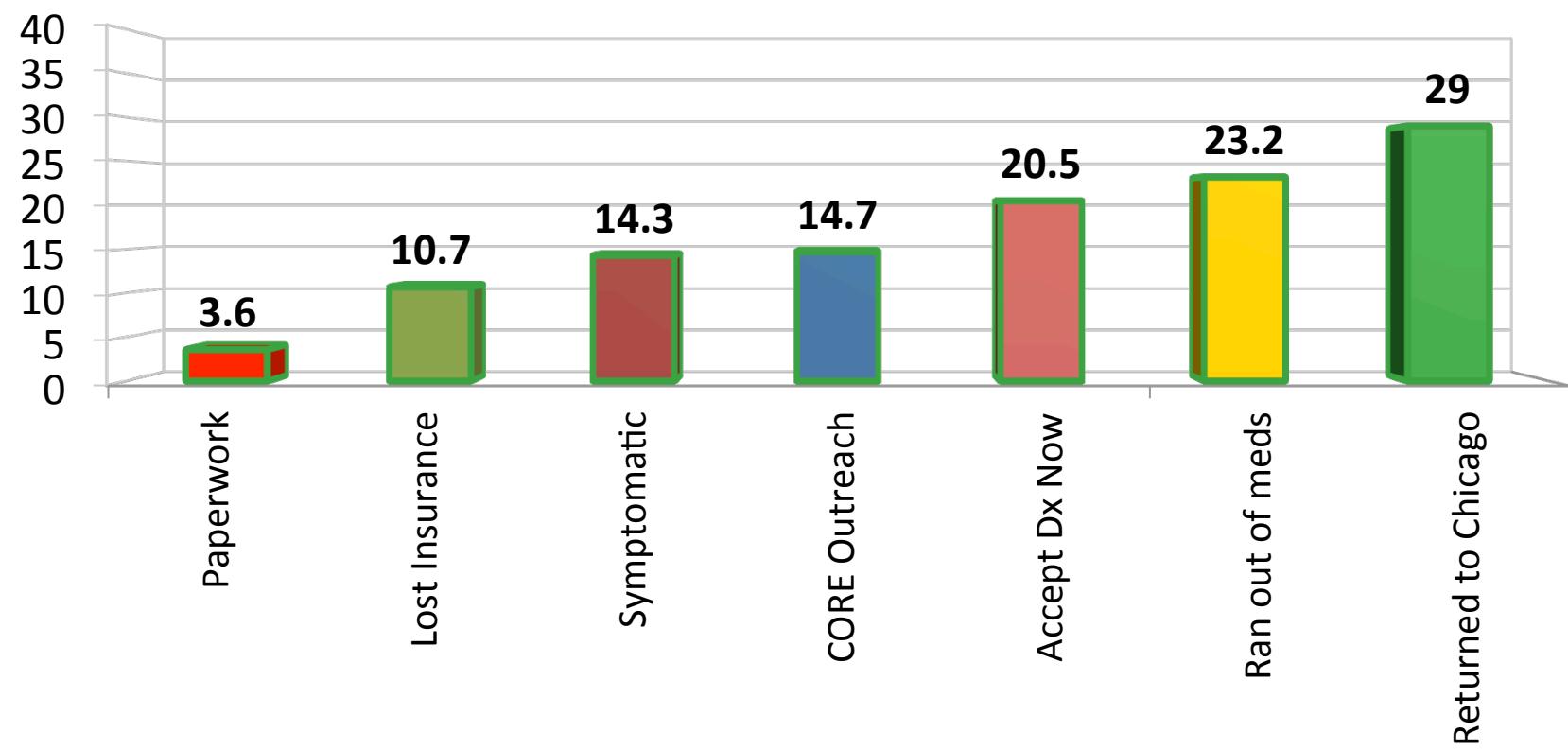


Notably not on this list: “Was Poorly Treated at CORE” 0.5%  
and “Clinic Schedule Not Convenient” at 4.1%

# CORE Return to 2014 Care Survey

## Top 3 reasons for *returning*

N=221



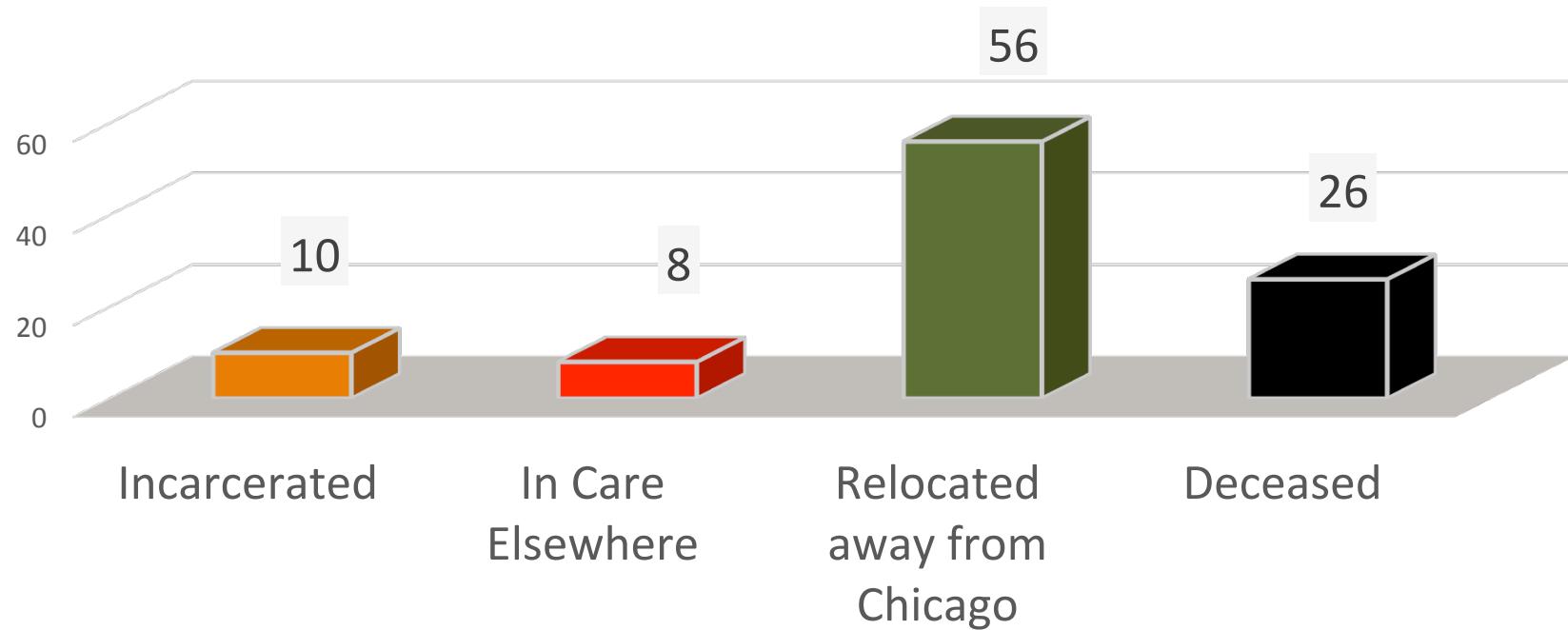
# CORE Outreach Efforts

## In 2014, patients not seen in 6-12mo

Reason for Dropping out of Care at CORE Center

Patient or EC reached by Phone n=254

Percentages of respondents



# Public Health Approach

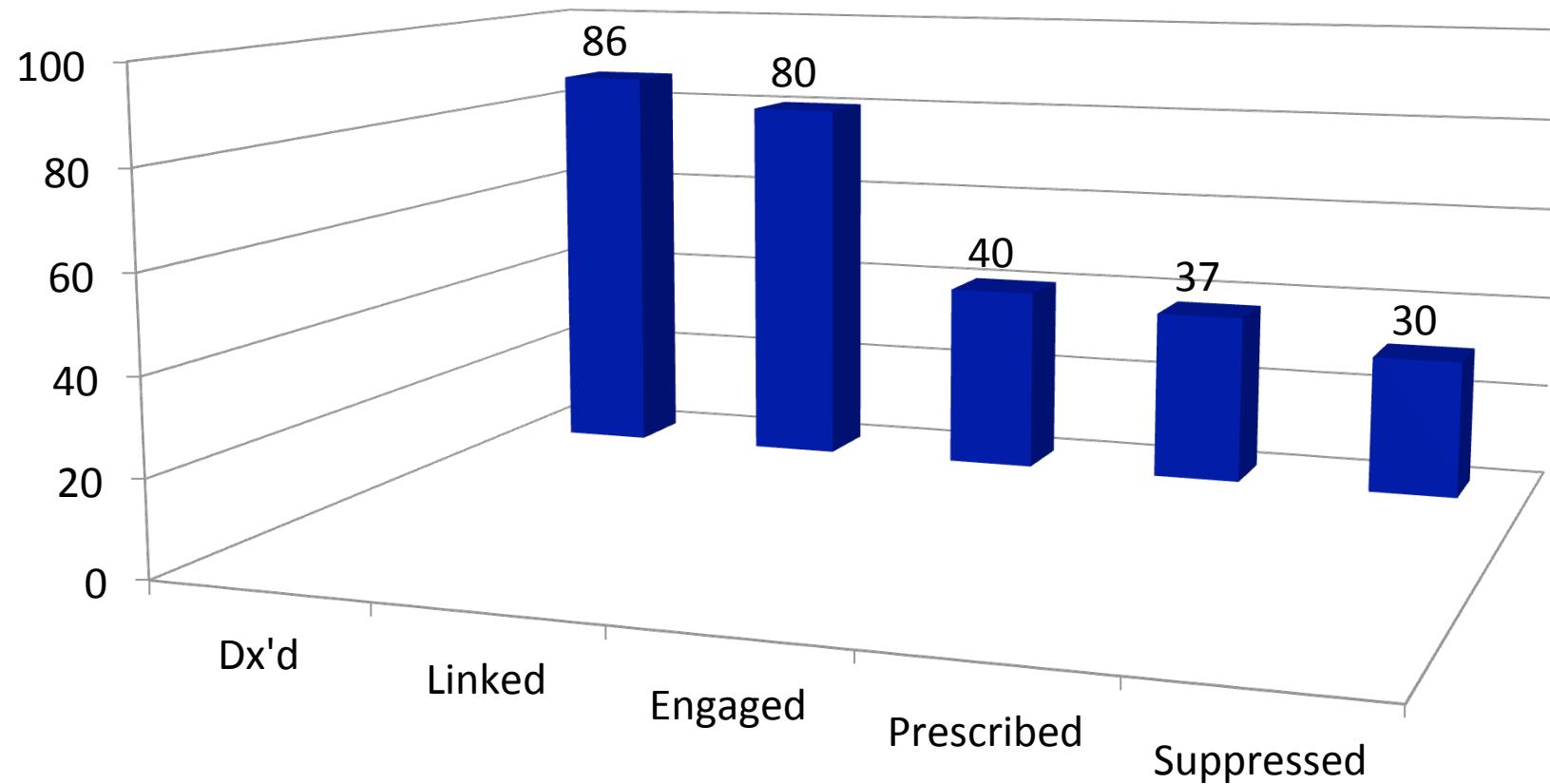
- CORE is by far largest single provider and CCHHS largest system.
- Promote widespread routine testing for HIV in CCHHS and partners – down to provider level?
- Maintain easy Access to HIV Clinics
- Outreach to newly diagnosed, linkage to care (affected by change in CDPH model for Outreach vs. EIS)
- Evolution to Patient Centered Medical Home to improve retention in Care
- Measure virologic suppression as community viral load and provider specific outcome.

# WHO (proposed) Ambitious approach for 2020 is 90/90/90

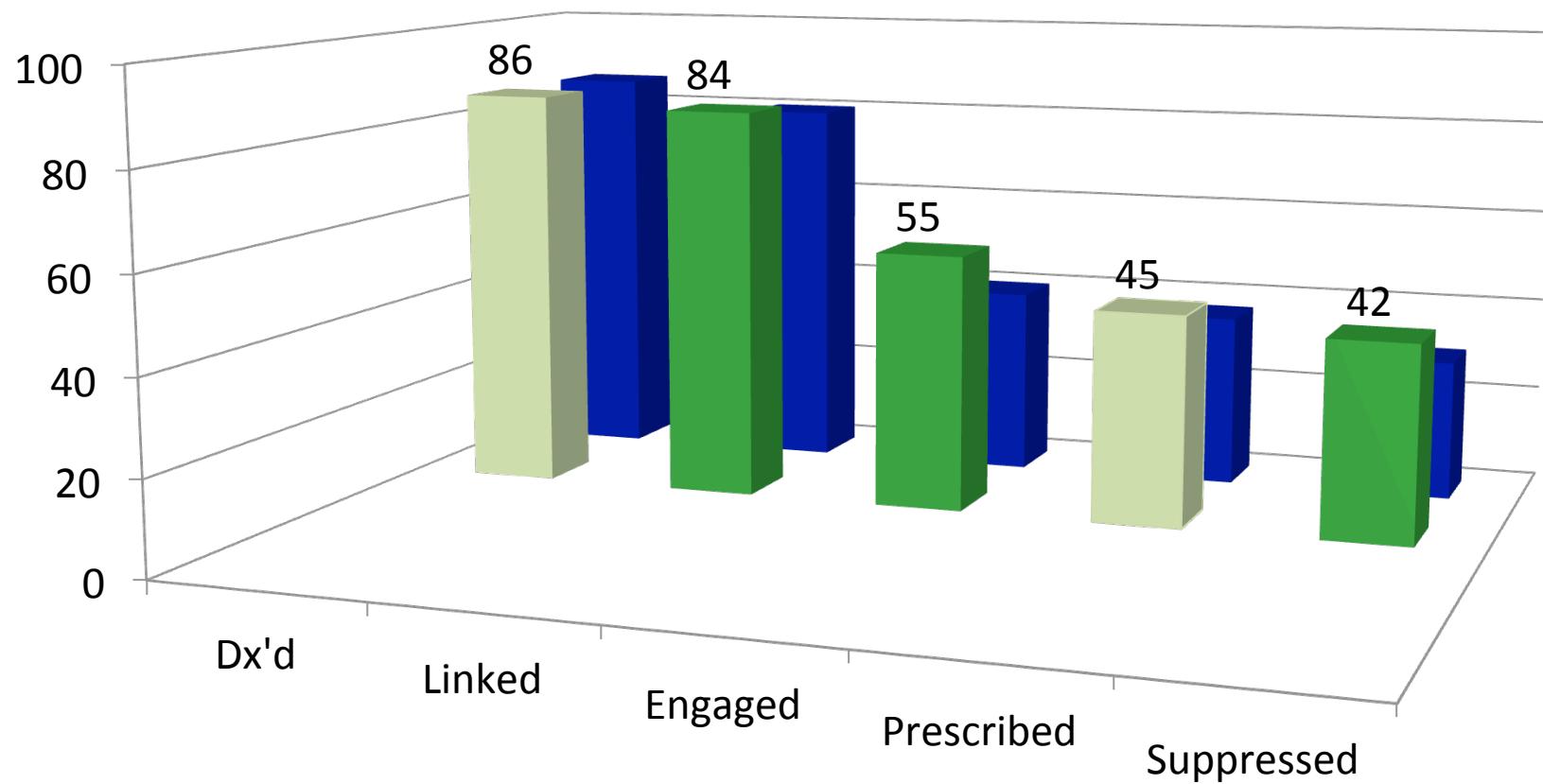
- 90% of people with HIV have been diagnosed
  - 90% of those are in care
  - 90% of those in care are suppressed
- 
- In CCHHS we are at 86%+ dx'd (estimated)
  - Of those 78% are engaged in Care
  - Of those 86% are suppressed

# CDC HIV Treatment Cascade (2011)

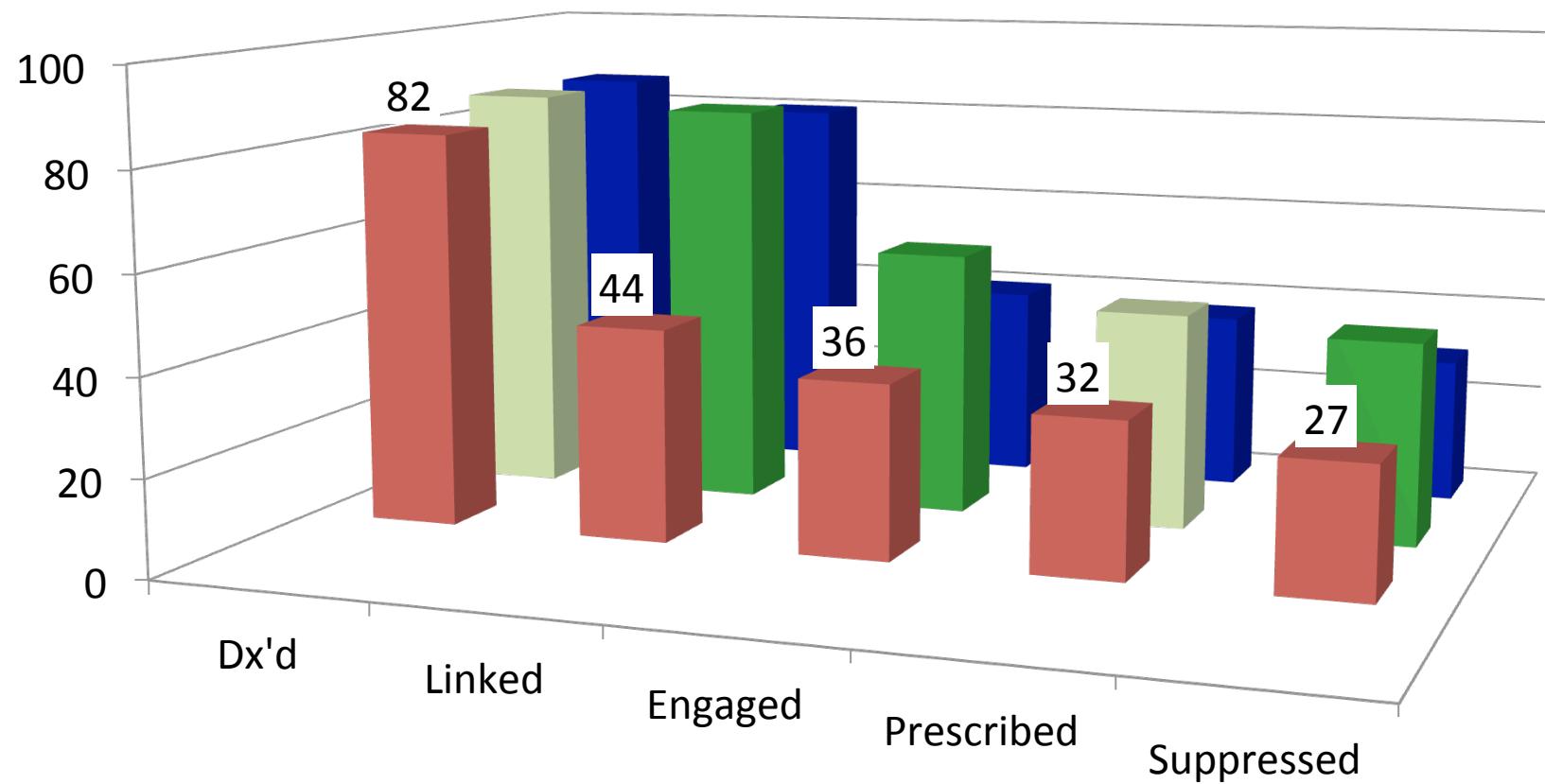
## Entire United States



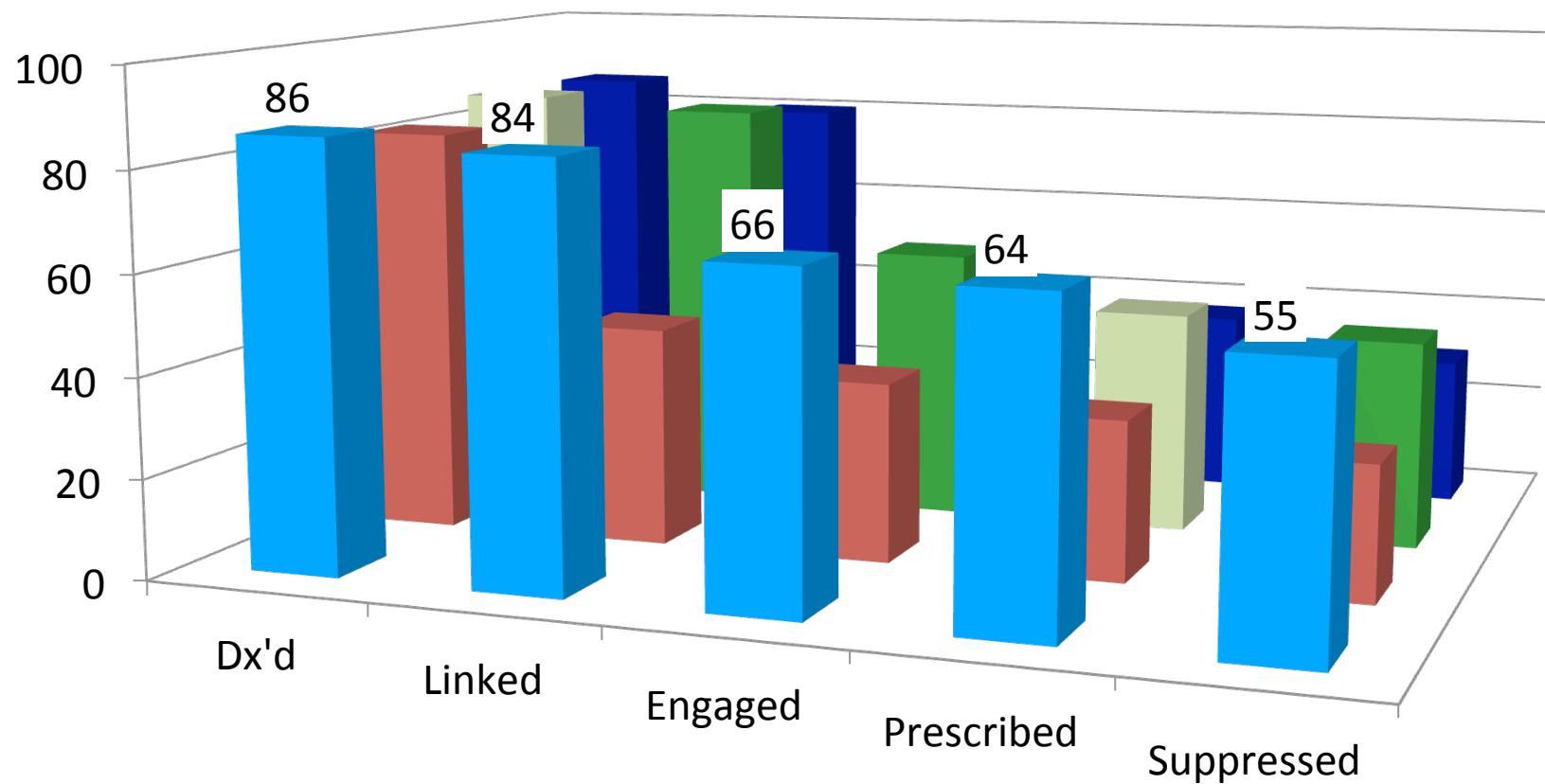
# CDC/US 2011, IDPH 2013



# CDC/US 2011, IDPH 2013, CDPH 2011

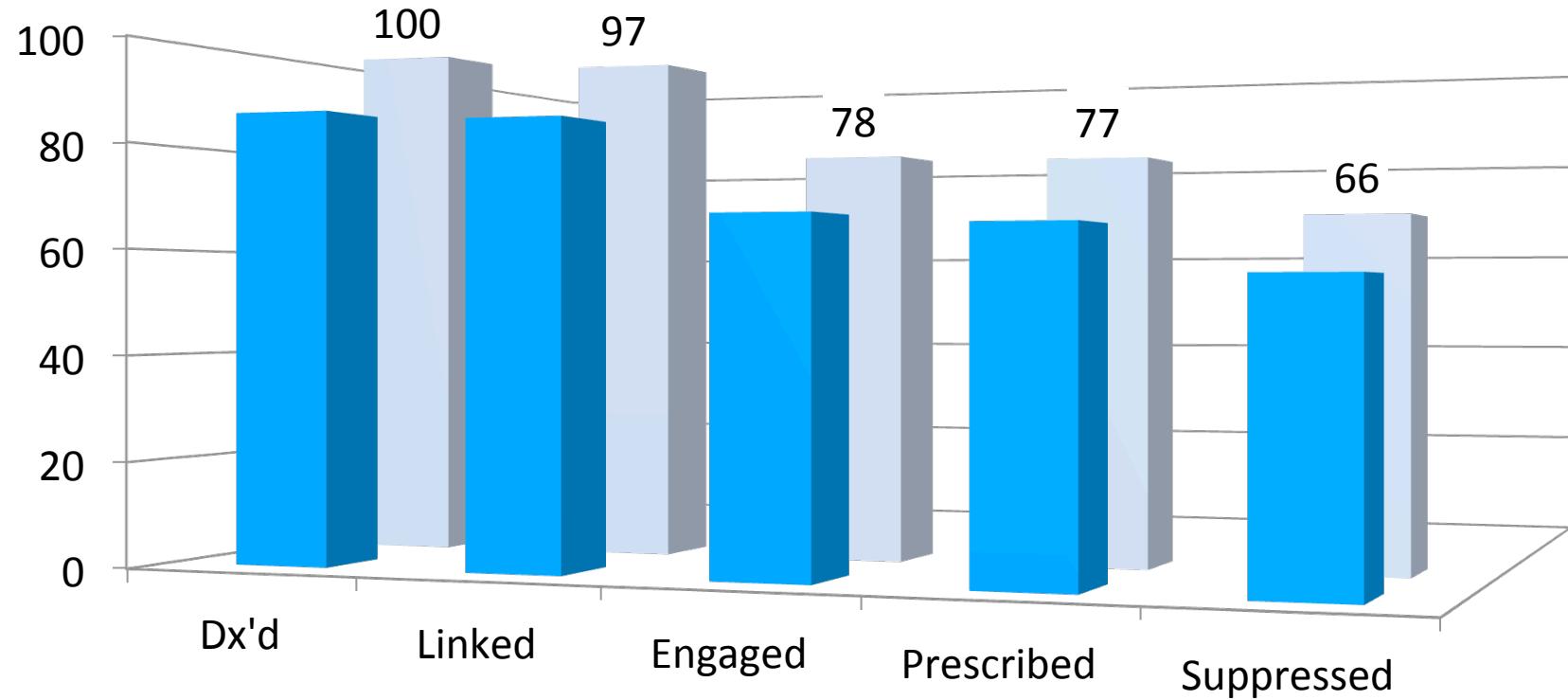


# CDC/US 2011, IDPH 2013, CDPH 2011, CORE 2014

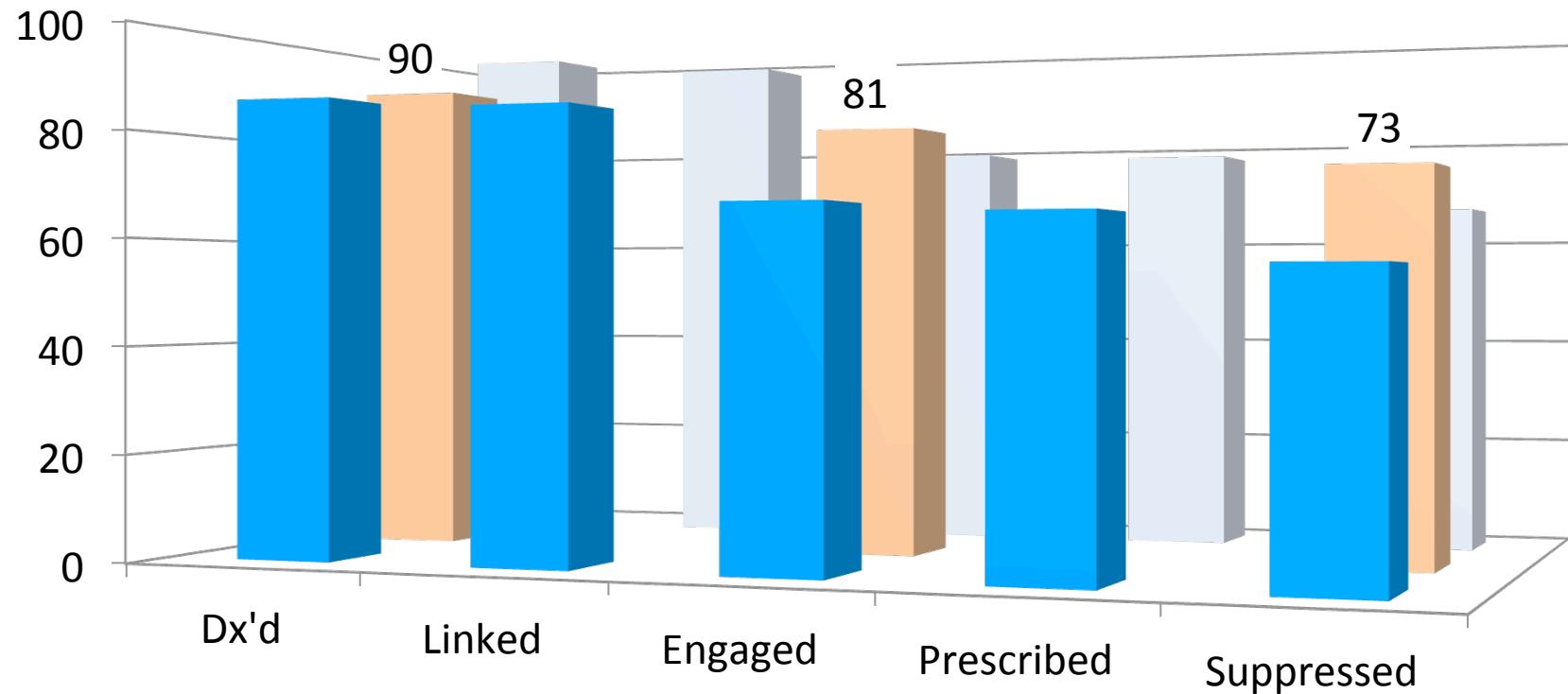


# CORE by Cascade

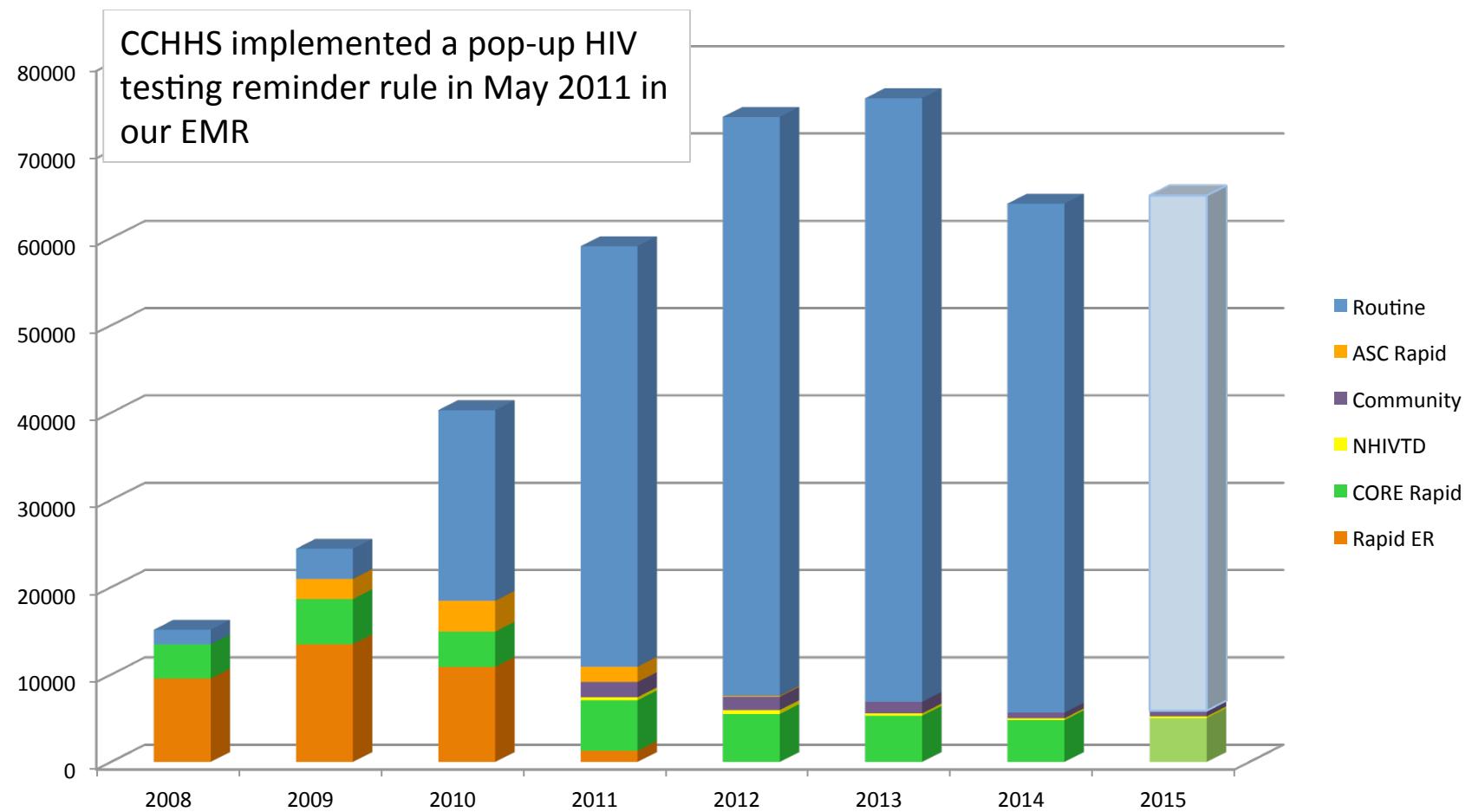
## vs. CORE if 100% diagnosed



# CORE Cascade vs. WHO 90/90/90 for 2020



# Total HIV tests CCHHS incl. 2015 projection

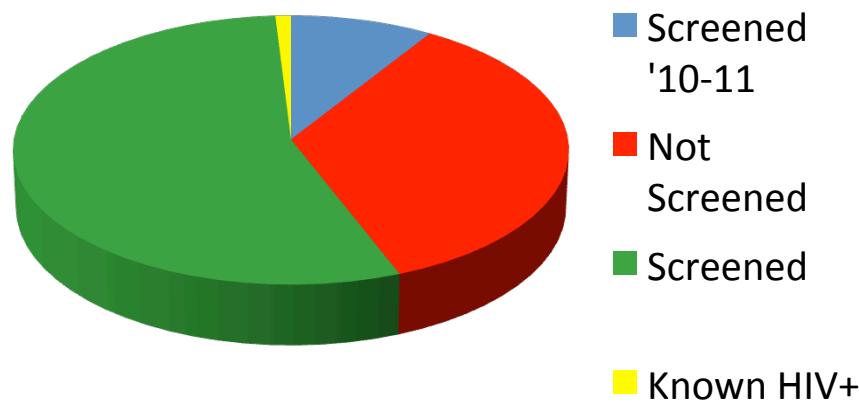


# Screening Effectiveness in CCHHS

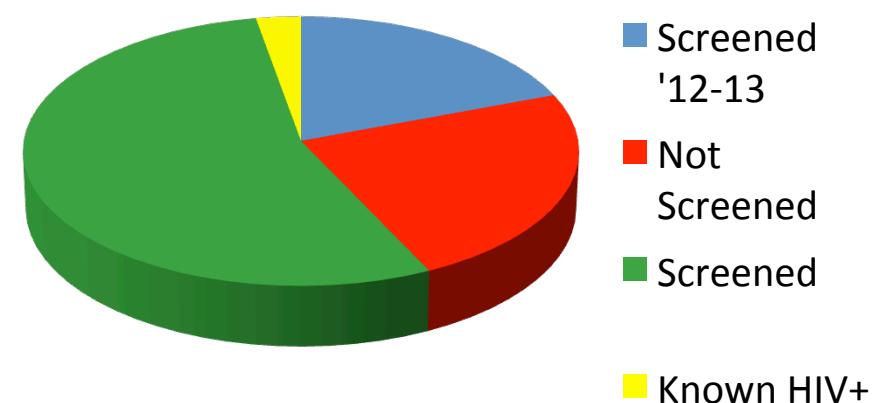
- Why did testing decline in 2014?
  - Providers burned out on testing?
  - Higher proportion of patients tested in past 2 years (reaching saturation)?
- Lab based QA
  - Total patients who had at least one blood test done in 2012 and 2014 per care venue within CCHHS (e.g. ER)
  - %who had HIV test in prior 2 years (2010-2011 and 2012-2013)
  - %who had test done this encounter
  - %known to be HIV positive
    - This mimics the logic of HIV Reminder Pop-up Rule

# SHCC Inpt. Fraction not screened decreased from 35% to 24%

2012 SHCC Inpatient

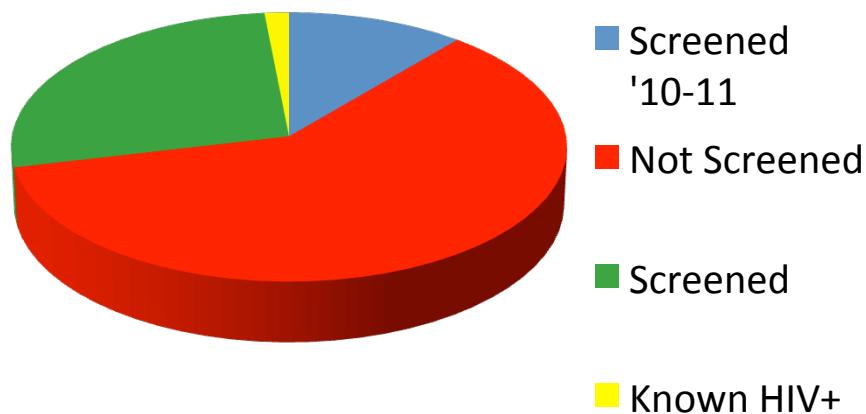


2014 SHCC Inpatient

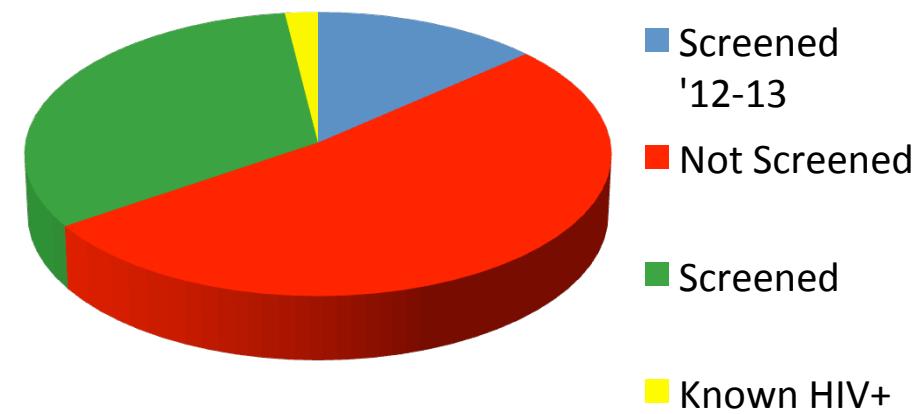


# SHCC ER Fraction not screened decreased from 60% to 52%

2012 SHCC ER



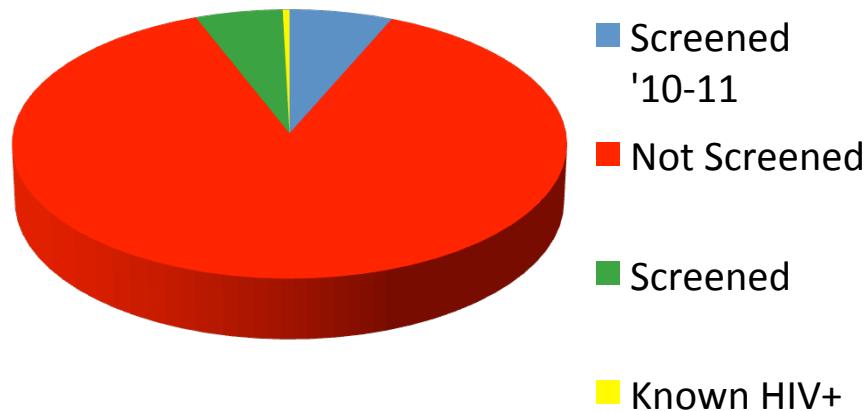
2014 SHCC ER



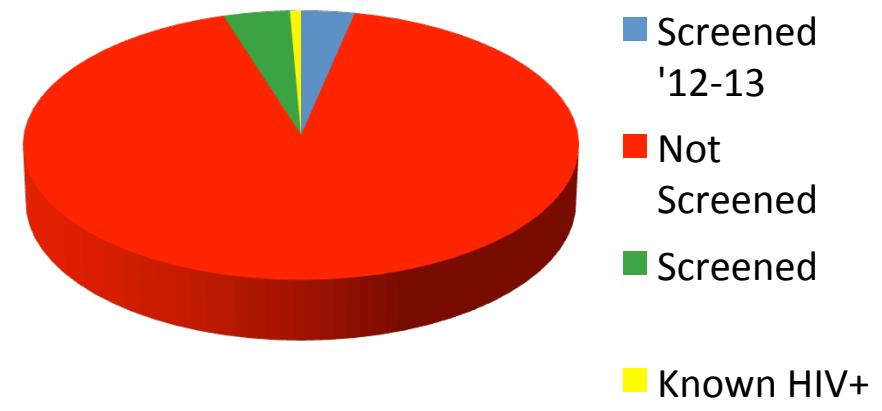
# PHCC ER Fraction not screened

*Increased* from 87% to 91%

2012 PHCC ER

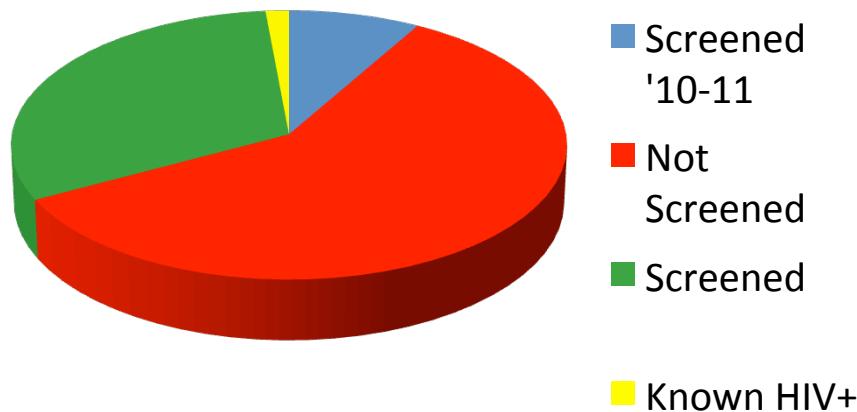


2014 PHCC ER

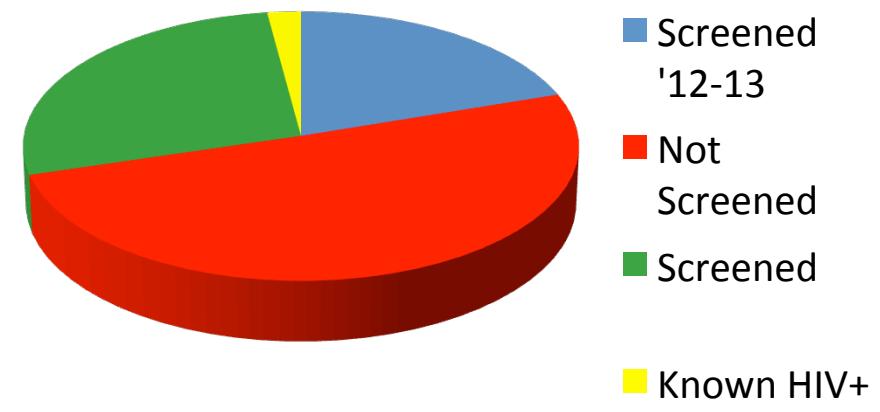


# ACHN Fraction not screened decreased from 58% to 51%

2012 ACHN



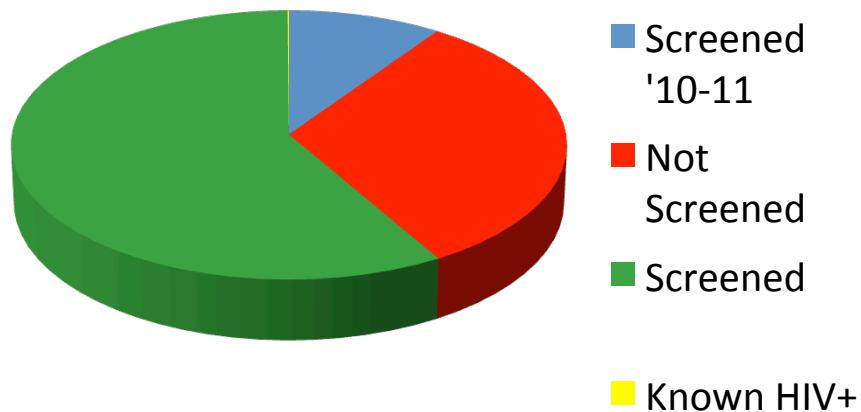
2014 ACHN



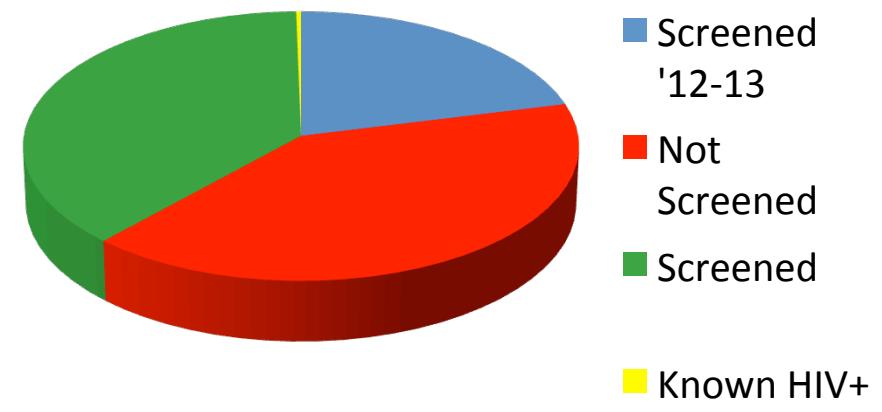
# Cermak Fraction not screened

*Increased* from 31% to 40%

2012 Cermak



2014 Cermak



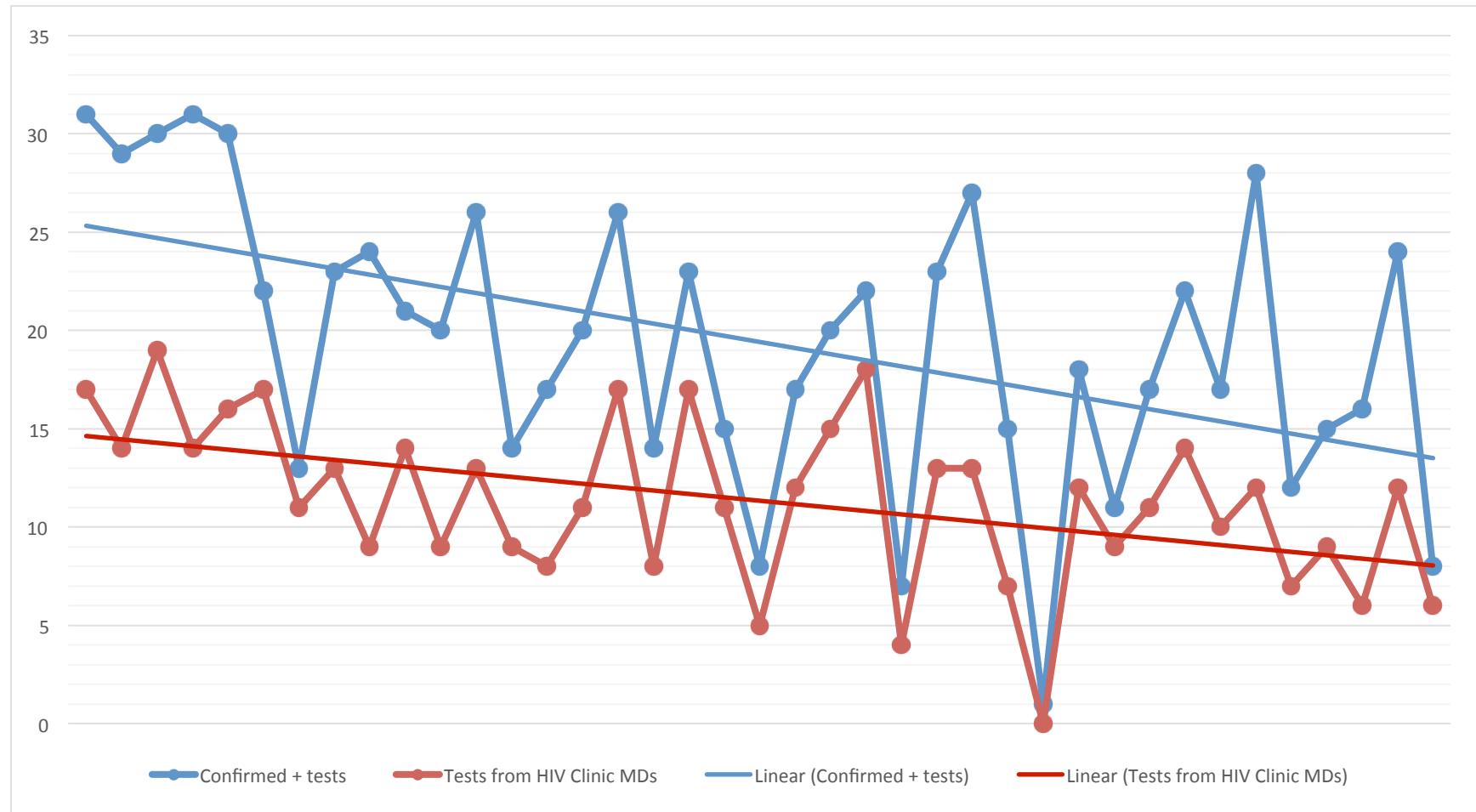
# Overall HIV testing (as a proportion of patients) has increased

- Some areas (SHCC Inpatient, ACHN, SHCC ER) are benefiting from prior testing with resulting increases in overall fraction tested.
- SHCC ER, SHCC Inpt., and ACHN are increasing testing though slowly.
- Some areas that have very high HIV prevalence (PHCC ER, Cermak) are not testing at adequate frequency and their performance is worsening over time.

# There is room for improvement in HIV Testing within CCHHS

- Clinical Departments should be required to set targets within their areas.
  - WHO target is 90%
  - CDC target is 100%
- Consideration should be given to tracking the fraction of patients tested down to the individual attending level for OPPE.
  - This is possible based on infrastructure built for Meaningful Use of EMR.

# Past 52 weeks, #of positives and fraction that are true screening vs. confirmatory on patients referred in from outside.



Suggests we may be exhausting pool of undx'd positive patients in CCHHS<sub>31</sub>

# Maintaining Early Access at CORE HIV Primary Care Clinics

## Time to 1<sup>st</sup>/3<sup>rd</sup> New Appointment

<b>Service &gt;&gt; Date checked</b>	6/8/2014	6/8/2014 4 3rd New	9/16/2014	9/16/2014 3rd New	12/5/2014	12/5/2014 3rd New	3/6/2015	3/6/2015 3rd New	6/16/2015	6/16/2015 3rd New
<b>HIV Primary Care CORE Standard ≤10 business days</b>										
<b>Adult HIV Primary Care</b>	6/17/2014	7	6/23/2014	11	9/19/2014	3	9/23/2014	4	12/12/2014	5
									12/16/2014	7
									3/9/2015	1
									3/9/2015	1
<b>Women's HIV Primary Care</b>	6/10/2014	2	6/10/2014	2	9/24/2014	7	9/24/2014	7	12/10/2014	3
									12/17/2014	8
									3/18/2015	8
									3/20/2015	10
									6/17/2015	1
<b>Bilingual HIV Primary Care</b>	6/9/2014	1	6/12/2014	4	9/18/2014	2	9/18/2014	2	12/11/2014	4
									12/22/2014	11
									3/9/2015	1
									3/12/2015	4
									6/18/2015	2
<b>Continuity (Correctional) Care</b>	6/11/2014	3	6/11/2014	3	9/17/2014	1	9/17/2014	1	12/10/2014	3
									12/17/2014	8
									3/11/2015	3
									3/11/2015	3
									6/17/2015	1
									6/17/2015	1

Average waiting time for a new HIV Clinic appointment at CORE has been <1 week over past 4 quarters

# Maintaining Early Access at CORE

Average waiting time for a new HIV Clinic appointment at CORE has been <1 week over past 4 quarters

# Linkage to Care

- Denominator: patients who have first time confirmed HIV+ tests anywhere in CCHHS prior 3 month period
- Numerator: *of these*, patients who had a visit (not just an appointment) at a CCHHS site that provides HIV primary care
- Measure added to CORE STAR Report for 2014
- FY2014 91% had at least 1 HIV clinic visit
- First 7 mo. FY2015 = 97%
- *CORE lost 3 Outreach Workers due to CDPH realignment of Outreach programs*

# Retained/Engaged in Care at CORE

- Denominator: all patients who have any visit at CORE in prior 12 months
- Numerator: *of these*, patients who had >2 visits at CORE >90 days apart (HRSA Defined)
  - Measure added to CORE STAR Report for 2014
- For FY2014 77% of patients were retained/engaged
- For first 7 mo. Of FY2015 = 78%

# Virologic Suppression Among those Engaged in Care

- Denominator: all viral load (VL) measurements at CORE during prior month from Engaged/Retained patients
- Numerator: proportion of all VL that show reasonable virologic control
- Corresponds to cascade measure, but may underestimate success in patient getting labs but skipping visits
- FY2014 86% of engaged pts. Suppressed
- First 7 mo. of FY2015 87% are suppressed

# Virologic Suppression Community Viral Load

- Denominator: *all* viral load (VL) measurements at CORE during prior month
- Numerator: proportion of all VL that show reasonable virologic control
- Crude but powerful overall measure of treatment efficacy (of those coming to care)
- FY2014 CVL suppression 86%
- First 7 mo. Of FY2015 = 88%

# Provider summaries

- 25 measures of process and outcome
- Assesses all patients who have PCP relationship with that provider
- Given to each provider ~semi-annually
  - With comparison column for similar providers
  - With comparison column for all CORE providers
- Includes some Primary care measures –
  - e.g. HgBA1C

# 2014 CORE Performance Measures

<b>2014 Performance Measures</b>	<b>num</b>	<b>denom</b>	<b>%</b>
Retention	3434	4328	79.3%
Two Primary Care Visits>= 3mos Apart %	3434	4328	79.3%
Percentage with>=2 CD4 Counts %	3024	4329	69.9%
Percentage with>=2 Viral Load Counts %	3056	4329	70.6%
Viral Load Suppression (<1000 copies/mL) %	3517	3829	91.9%
Viral Load Suppression (<200 copies/mL) %	3362	3829	87.8%
Viral Load Monitoring (test performed at least every 6 mos) %	2178	3553	61.3%
Cervical Cancer Screening within last 12mos %	383	1144	33.5%
Cervical Cancer Screening within last 18mos %	494	1144	43.2%
Cervical Cancer Screening within last 24mos %	608	1144	53.1%
Hepatitis B Screening %	4296	4382	98.0%
Hepatitis C Screening %	4293	4388	97.8%
Lipid Screening %	3020	4245	71.1%
Syphilis Screening (general population >=1 visit) %	3608	4363	82.7%
Syphilis Screening (engaged population >=2 visits at 6mos apart) %	2430	2776	87.5%
Chlamydia Screening w/a prior STI positive screening within last 12 mos %	637	854	74.6%
Chlamydia Screening (general population >=1 visit) %	2537	4362	58.2%
Gonorrhea Screening w/a prior STI positive screening within last 12 mos %	637	854	74.6%
Gonorrhea Screening (general population >=1 visit) %	2537	4362	58.2%
HIV+ in continuous care with a CD4 count >=200 %	2894	3434	84.3%
HIV+ in continuous care with a CD4 count >=350 %	2146	3434	62.5%
Diabetics Annual A1c %	238	301	79.1%
Diabetics Annual A1c < 9 %	190	238	79.8%
Diabetics Annual Lipids Panel %	238	301	79.1%
Diabetics Annual Lipids Panel LDL < 100 (%)	161	238	67.6%

# CCHHS Wide HIV Programs

CCHHS HIV Site Performance_Measure	SSHARC			ACHN Austin			Num.	PHCC HIV			Num.	CORE	
	Num.	Denom.	%	Num.	Denom.	%		Denom.	%	Denom.		Denom.	%
Two Primary Care visits>= 3mos Apart (retention)	248	303	81.85%	82	91	90.11%	361	396	91.16%	3434	4328	79.30%	
Percentage with >=2 CD4 Counts	206	303	67.99%	71	91	78.02%	272	361	94.74%	3024	4329	69.90%	
Percentage with >=2 Viral Load Counts	207	303	68.32%	75	91	82.42%	343	361	95.01%	3056	4329	70.60%	
Viral load suppression (<1000)	212	237	89.45%	72	81	88.89%	351	361	97.23%	3517	3829	91.90%	
Viral load suppression (< 200)	205	237	86.50%	72	81	88.89%	347	361	96.12%	3362	3829	87.80%	
Viral load monitoring every 6 months	135	256	52.73%	51	80	63.75%	273	361	75.62%	2178	3553	61.30%	
Cervical Cancer Screening within last 12 mos.	22	60	36.67%	13	21	61.90%	55	80	68.75%	383	1144	33.50%	
Cervical Cancer Screening within last 18 mos.	26	60	43.33%	15	21	71.43%				494	1144	43.20%	
Cervical Cancer Screening within last 24 mos.	32	60	53.33%	16	21	76.19%				608	1144	53.10%	
Cervical Cancer Screening within last 36 mos.	33	55	60.00%	17	21	80.95%							
Hepatitis B Screening	219	235	93.19%	79	87	90.80%				4296	4382	98.00%	
Hepatitis C Screening	331	340	97.35%	98	105	93.33%	347	361	96.00%	4293	4388	97.80%	
Lipid Screening	250	319	78.37%	74	98	75.51%	308	361	85.31%	3020	4245	71.10%	
Syphilis screening	169	339	49.85%	86	105	81.90%	323	361	89.50%	2430	2776	87.50%	
Chlamydia Screening	101	121	83.47%	32	42	76.19%	245	361	67.86%	637	854	74.60%	
Gonorrhea Screening	101	121	83.47%	32	42	76.19%	245	361	67.86%	637	854	74.60%	
HIV+ in continuous care with a CD4 count >=350	239	239	100.00%	70	70	100.00%	253	361	70.01%	2146	3434	62.50%	
HIV+ in continuous care with a CD4 count >=200	239	239	100.00%	70	70	100.00%	315	361	87.26%	2894	3434	84.30%	
Diabetics Annual A1c	9	14	64.29%	-	-	-				238	301	79.10%	
Diabetics Annual A1c < 9	6	14	42.86%	-	-	-				190	238	79.80%	
Diabetics Annual Lipids	9	14	64.29%	-	-	-				238	301	79.10%	
Diabetics Annual Lipids LDL < 100	4	14	28.57%	-	-	-				161	238	67.60%	

# Sample Provider Summary

2014 Performance Measures	Dr. XXXX			MDs			ALL CORE		
	num	denom	%	num	denom	%	num	denom	%
Retention	93	100	93%	2063	2746	75%	3434	4321	79%
Two Primary Care Visits>= 3mos Apart %	110	123	89%	2382	3055	78%	3434	4328	79%
Percentage with>=2 CD4 Counts %	101	123	82%	2083	3055	68%	3024	4329	70%
Percentage with>=2 Viral Load Counts %	98	123	80%	2110	3055	69%	3056	4329	71%
Viral Load Suppression (<1000 copies/mL) %	97	110	88%	2227	2429	92%	3517	3829	92%
Viral Load Suppression (<200 copies/mL) %	95	110	86%	2133	2429	88%	3362	3829	88%
Viral Load Monitoring (test performed at least every 6 mos) %	68	113	60%	1478	2483	60%	2178	3553	61%
Cervical Cancer Screening within last 12mos %	0	5	0%	225	758	30%	383	1144	33%
Cervical Cancer Screening within last 18mos %	1	5	20%	282	758	37%	494	1144	43%
Cervical Cancer Screening within last 24mos %	5	5	100%	339	758	45%	608	1144	53%
Hepatitis B Screening %	125	130	96%	3117	3251	96%	4296	4382	98%
Hepatitis C Screening %	125	130	96%	3138	3281	96%	4293	4388	98%
Lipid Screening %	99	125	79%	2151	3056	70%	3020	4245	71%
Syphilis Screening (general population >=1 visit) %	118	129	91%	2760	3265	85%	3608	4363	83%
Syphilis Screening (engaged population >=2 visits at 6mos apart) %	76	81	94%	1717	1922	89%	2430	2776	88%
Chlamydia Screening w/a prior STI positive screening within last 12 mos %	31	38	82%	657	923	71%	637	854	75%
Chlamydia Screening (general population >=1 visit) %	83	129	64%	1961	3265	60%	2537	4362	58%
Gonorrhea Screening w/a prior STI positive screening within last 12 mos %	31	38	82%	657	923	71%	637	854	75%
Gonorrhea Screening (general population >=1 visit) %	83	129	64%	1961	3265	60%	2537	4362	58%
HIV+ in continuous care with a CD4 count >=200 %	95	110	86%	1950	2382	82%	2894	3434	84%
HIV+ in continuous care with a CD4 count >=350 %	67	110	61%	1442	2382	61%	2146	3434	62%
Diabetics Annual A1c %	7	10	70%	154	199	77%	238	301	79%
Diabetics Annual A1c < 9 %	6	7	86%	126	154	82%	190	238	80%
Diabetics Annual Lipids Panel %	9	10	90%	155	199	78%	238	301	79%
Diabetics Annual Lipids Panel LDL< 100 (%)	6	9	67%	114	155	74%	161	238	68%

# Pre-Exposure Prophylaxis - PrEP

- Giving a combination of two HIV medicines to persons at high risk to *prevent* HIV infection
  - Effective at preventing infection if med taken every day
  - Risk of developing resistance if becomes infected
  - Low risk of drug toxicity – but requires lab tests
- CDC Recommendations for PrEP in May 2014
- Is not Cost-Effective
  - Limited budget for HIV meds – CORE / CCHHS will not bear cost of meds – MAP or Insurance
- CORE opened PrEP clinic in April 2015
  - Serving 40-50 patients mostly high risk MSM

# Thank you

## Ruth M. Rothstein **C O R E**



Thanks to our patients for being surveyed, CCHHS providers for testing, Stephon Effinger, Jennifer Catrambone, Art Moswin, for data; and Chet Kelly for data and a thoughtful review.

# COOK COUNTY HEALTH & HOSPITALS SYSTEM



## Illinois Surgical Quality Improvement Collaborative (ISQIC)

Mark A Wille, MD, FACS  
Attending Physician (Urology),  
Department of Surgery  
CCHHS Surgeon Champion



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# Illinois Surgical Quality Improvement Collaborative (ISQIC)

- Collaborative comprised of:
  - 54 Illinois hospitals
  - The Illinois and Metropolitan Chicago Chapters of the American College of Surgeons
  - The American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP)
  - The Surgical Outcomes and Quality Improvement Center (SOQIC)
  - Blue Cross Blue Shield of Illinois



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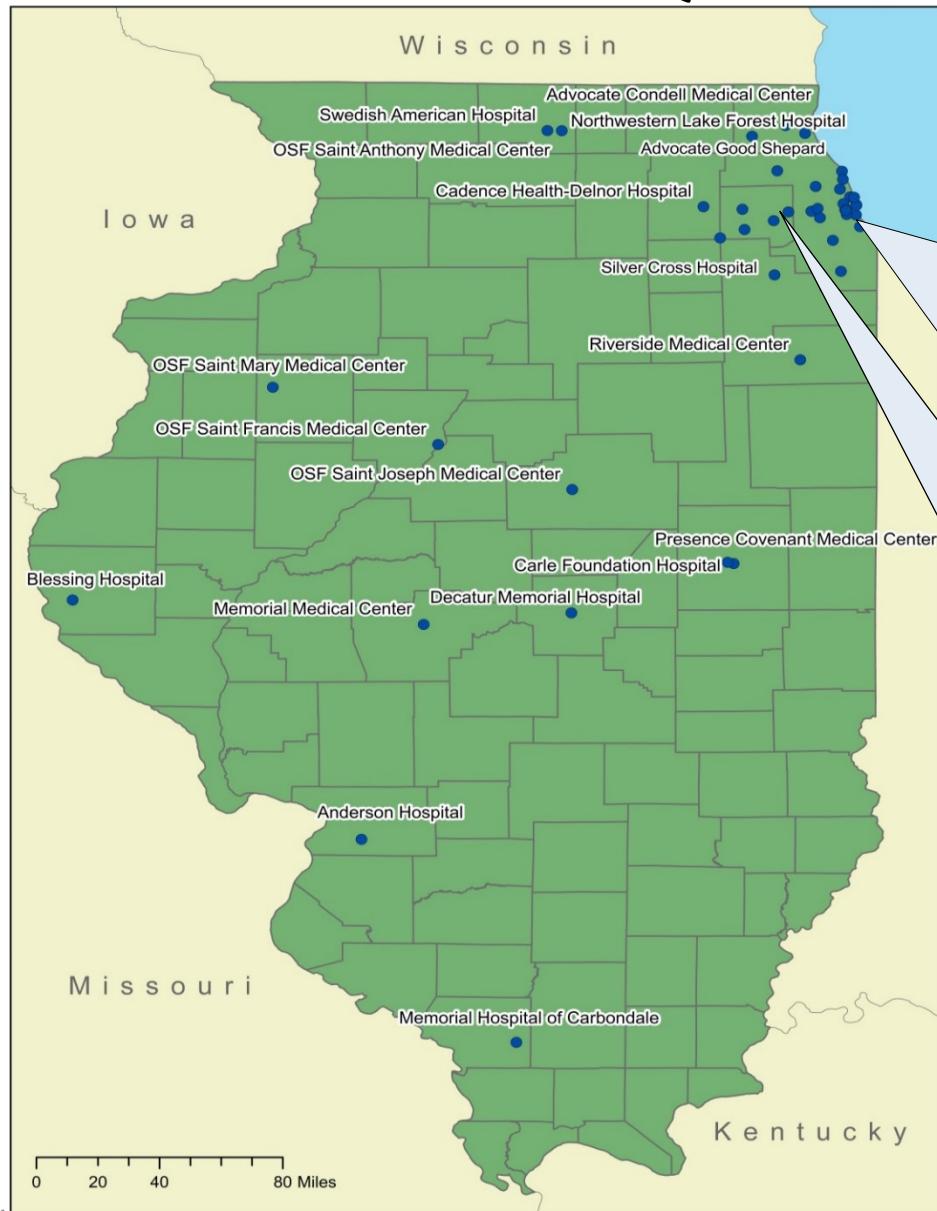
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# ISQIC Objective

To obtain rapid, meaningful, and sustained improvement in surgical quality by facilitating engagement in mentored, targeted Quality improvement/ Process Improvement initiatives



# 54 ISQIC Hospitals



## Cook County Hospitals

Advocate Christ Medical Center  
Advocate Illinois Masonic Medical Center  
Advocate South Suburban Hospital  
Ann & Robert H. Lurie Children's Hospital of Chicago  
John H. Stroger Jr. Hospital of Cook County  
Loyola University Health System  
MacNeal Hospital  
Mercy Hospital and Medical Center  
Mount Sinai Hospital  
NorthShore University HealthSystem (Evanston)  
Northwest Community Hospital  
Northwestern Memorial Hospital  
Presence Resurrection Medical Center  
Presence Saint Francis Hospital  
Presence Saint Joseph Hospital  
Presence Saint Mary and Elizabeth Medical Center  
Rush Oak Park Hospital  
Rush University Medical Center  
Swedish Covenant Hospital  
University of Chicago Medical Center  
University of IL Hospital & Health Sciences System

## DuPage County Hospitals

Edward Hospital  
Advocate Good Samaritan Hospital  
Cadence Health-Central DuPage Hospital  
Rush-Copley Medical Center  
Elmhurst Memorial Hospital



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# **Responsibilities of CCHHS (Required for Funding)**

- Implement American College of Surgeons National Surgical Quality Improvement Collaborative (ACS NSQIP)
- Participate in ISQIC Quality & Process Improvement Curriculum
- Participate in annual Collaborative Quality Improvement Project (CQIP)
- Attend semi-annual conferences
- Use ISQIC data to undertake two quality improvement projects
- Present ISQIC/NSQIP data to Hospital Board on an annual basis
- Demonstrate significant improvement in at least one area (outcome or process measure) by the end of year 3



# Our Hospital ISQIC Team

- Surgeon Champion: Mark A. Wille, MD, FACS
- Surgical Clinical Reviewer: Blessy Varghese, MSN, RN, CNOR
- QI Designee: Krishna Das, MD



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# ISQIC Overview

- We report detailed data on surgical cases and outcomes
- We receive comparative reports for our hospital
- Unique approaches to facilitate improvement
- Funding to cover participation costs



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# ACS NSQIP Key Features

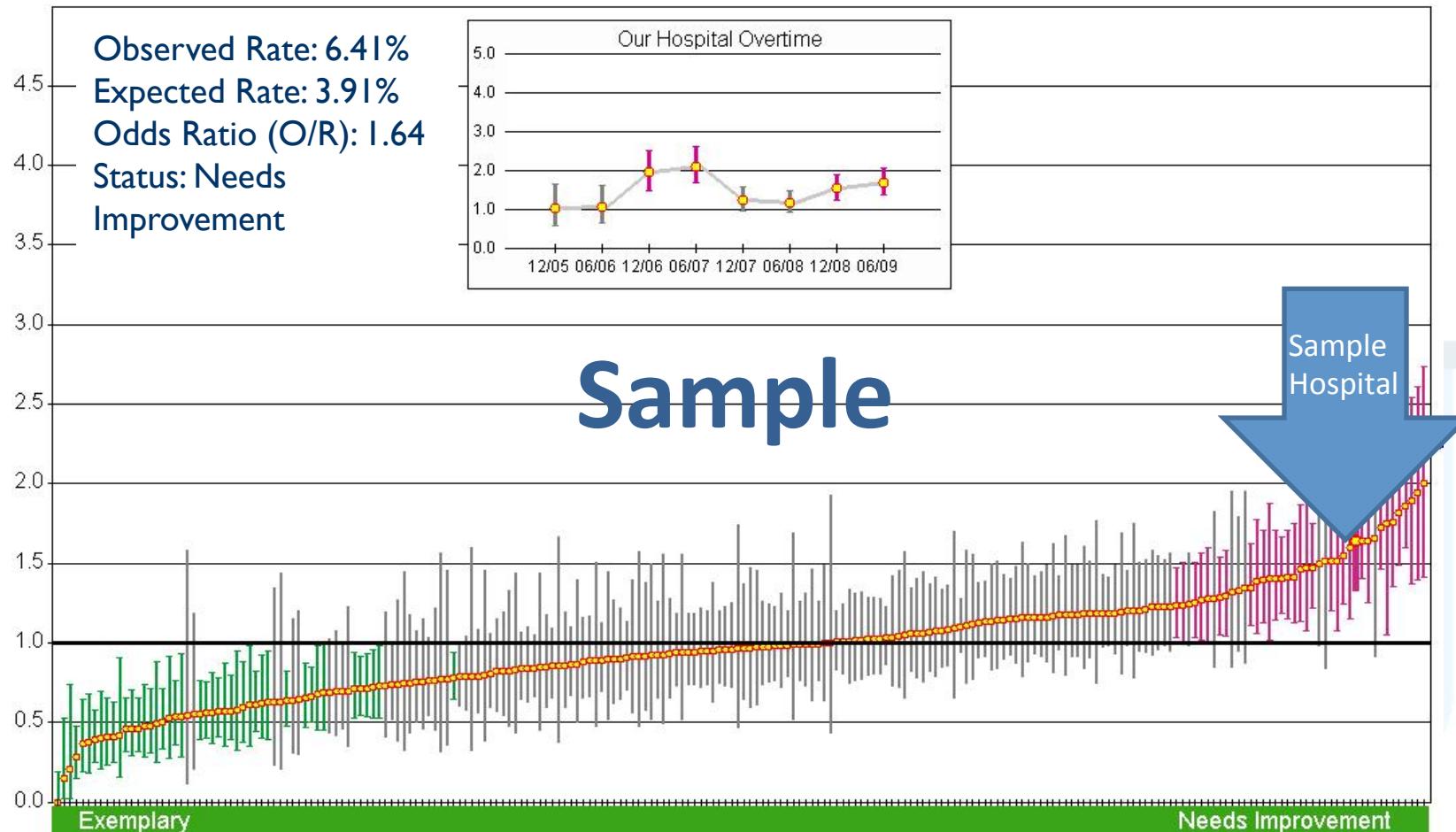
- Rigorous clinical data abstraction
  - Standardized data definitions
  - Abstract maximum of 40 cases per week (approximately 20% of surgical volume)
  - Trained data abstractor-Surgical Clinical Reviewer (SCR)
  - Comprehensive set of >70 risk factors
  - Intraoperative Data and Postoperative Outcomes
  - Externally audited data
  - Allows for rigorous risk adjustment
- All surgical subspecialties analyzed
- Risk-Adjusted Outcomes
  - 30-day morbidity, mortality, readmission & length of stay
  - 30+ Outcomes



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# Comparative Reports



# ACS NSQIP Works

## ORIGINAL ARTICLES

### Does Surgical Quality Improve in the American College of Surgeons National Surgical Quality Improvement Program An Evaluation of All Participating Hospitals

Bruce L. Hall, MD, PhD, MBA, FACS,\*†‡§ Barton H. Hamilton, PhD,§ Karen Richards, BS,¶  
Karl Y. Bilmoria, MD, MS,|| Mark E. Cohen, PhD,¶ and Clifford Y. Ko, MD, MS, MSHS, FACS\*\*¶

**Background/Objective:** The National Surgical Quality Improvement Program (NSQIP) has demonstrated quality improvement in the VA and pilot study of 14 academic institutions. The objective was to show that American College of Surgeons (ACS)-NSQIP helps all enrolled hospitals.

**Methods:** ACS-NSQIP data was used to evaluate improvement in hospitals longitudinally over 3 years (2005–2007). Improvement was defined as reduction in risk-adjusted “Observed/Expected” (O/E) ratio between periods with risk adjustment held constant. Multivariable logistic regression-based adjustment was performed and included indicators for procedure groups. Additionally, morbidity counts were modeled using a negative binomial model, to estimate the number of avoided complications.

**Results:** Multiple perspectives reflected improvement over time. In the analysis of 118 hospitals (2006–2007), 66% of hospitals improved risk-adjusted mortality (mean O/E improvement: 0.174;  $P < 0.05$ ) and 82% improved risk-adjusted complication rates (mean improvement: 0.114;  $P < 0.05$ ). Correlations between starting O/E and improvement (0.834 for mortality, 0.652 for morbidity), as well as relative risk, revealed that initially worse-performing hospitals had more likelihood of improvement. Nonetheless, well-performing hospitals also improved. Modeling morbidity counts, 183 hospitals (2007), avoided ~9598 potential complications: ~52/hospital. Due to sampling, this may represent only 1 of 5 to 1 of 10 of the true total. Improvement reflected aggregate performance across all types of hospitals (academic/community, urban/rural). Changes in patient risk over time had important contribution to the effect.

**Conclusion:** ACS-NSQIP indicates that surgical outcomes improve across all participating hospitals in the private sector. Improvement is reflected for both poor- and well-performing facilities. NSQIP hospitals appear to be avoiding substantial numbers of complications—improving care, and reducing costs. Changes in risk over time merit further study.

(Ann Surg 2009;250: 000–000)

From the \*Department of Surgery, John Cochran Veterans Affairs Medical Center, St. Louis, MO; †Washington University Center for Health Policy, St. Louis, MO; ‡Division of General and Vascular Surgery, Washington University School of Medicine, St. Louis, MO; §John Bunnell School at Washington University in St. Louis, St. Louis, MO; ||Division of Research and Optimal Patient Care, American College of Surgeons, Chicago, IL; ||Department of Surgery, Northwestern University School of Medicine, Chicago, IL; and \*\*Department of Surgery, University of California Los Angeles School of Medicine, Los Angeles, CA.

Supported by the Center for Health Policy, Washington University in Saint Louis, director William Peck, MD (to B.L.H.) and also by the American College of Surgeons Clinical Scholars in Residence program (to K.Y.B.).

The ACS-NSQIP data have been peer-reviewed and accepted. ACS NSQIP are the source of the data used herein; they have not been verified and are not responsible for the statistical validity of the data analysis or the conclusions derived by the authors.

This study does not represent the views or plans of the ACS or the ACS-NSQIP.

Reprints: Bruce L. Hall, MD, PhD, MBA, Campus Box 8109, 660 South Euclid Ave., St. Louis, MO 63110. E-mail: hallb@washu.edu.

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82%

OF HOSPITALS DECREASED COMPLICATIONS

66%

OF HOSPITALS DECREASED MORTALITY

POOR PERFORMERS AND TOP PERFORMERS IMPROVED



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# Cost Savings/ Return on Investment

Through participation in ACS NSQIP

- An average hospital can prevent approximately 250 complications per year
  - Cost of complication: \$10,000
  - Potential savings per hospital: \$2,500,000
- Examples of real savings include ACS NSQIP hospitals that have reduced costs by \$2M-2.5M.



# Successful Surgical Quality Collaboratives

***Michigan Surgical Quality Collaborative (MSQC)***



## Reduction in statewide complication rates

Sepsis	↓34%
Septic shock	↓37%
Pneumonia	↓29%
Prolonged ventilation	↓22%
SSI	↓13%
Cardiac arrest	↓33%



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# ISQIC Resources to Facilitate Improvement

- Formal quality and process improvement curriculum
- Surgeon Mentor
- Process improvement coach
- Customized, Illinois-specific benchmark reports
- Statewide collaborative QI projects
- Pilot grants
- Semi-annual meeting



# Funding

- CCHHS participation in ISQIC is underwritten by funding from Blue Cross and Blue Shield of Illinois.
  - Covers
    - Data abstractor / project manager
    - Collaborative participation
    - ACS NSQIP annual fee
- The Surgeon Champion's participation in the ISQIC is underwritten by funding from the Surgical Outcomes and Quality Improvement Center of Northwestern University.



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# Anticipated Return on Investment for ISQIC Hospitals

- 30% reduction in complications & death
- 25% fewer readmissions and reduced length of stay
- Savings of \$1-2 million per hospital

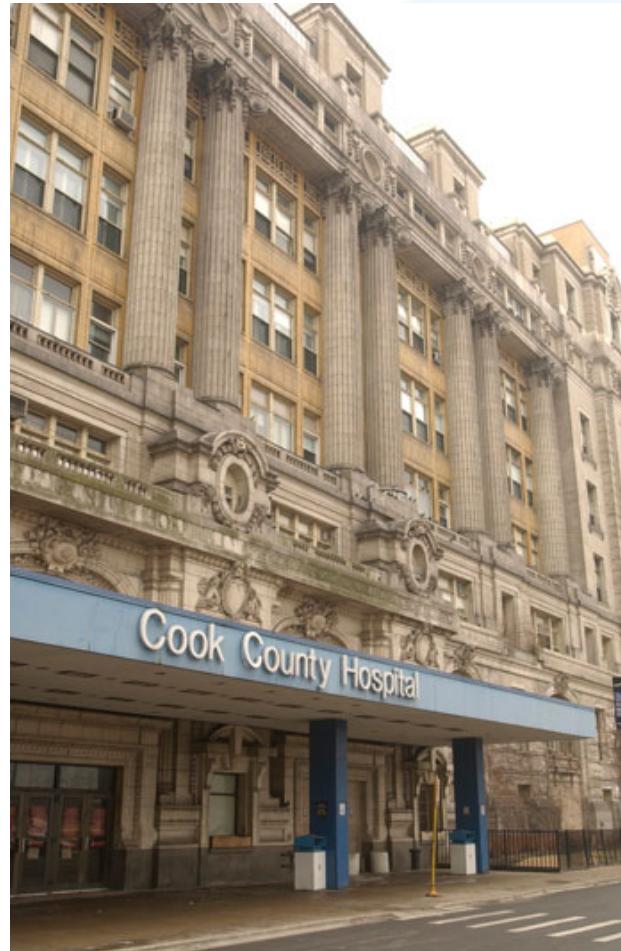


# What have we accomplished?

- Assembled our team
- Completed necessary training
- Abstracted >750 Cases as of 7/17/2015
- Streamlined our abstraction process
- Engaged in partnership with surgeon mentor
- Started data gathering for Illinois-wide project on Venous Thromboembolism
- Participating in 2015 Annual Meeting
- Eagerly anticipating our first Semi-annual report



# Thank you



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